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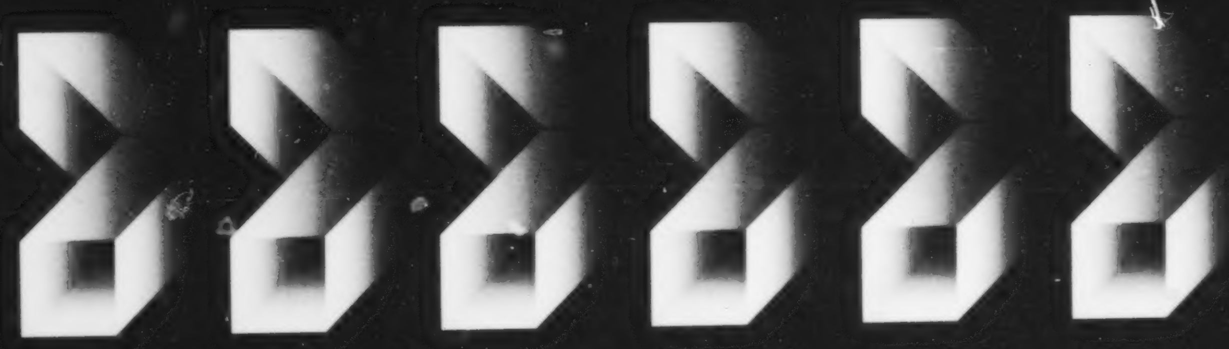

EVALUATION OF THE DIVISION OF AGING AND SENIORS/SENIORS STRATEGY

FINAL REPORT

DECEMBER 13, 1996

Canada

MISSION STATEMENT

The Evaluation Group helps Health Canada serve Canadians better by providing objective information and advice about the effectiveness of departmental activities and services.

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Evaluation of the Division of Aging and Seniors/Seniors Strategy

Final Report

December 13, 1996

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Evaluation Chronology

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EXECUTIVE SUMMARY

The purpose of this study was to evaluate the continuing relevance and accomplishments to date of the Division of Aging and Seniors/Seniors Strategy (DAS/S) as well as to determine if there are any alternatives. The DAS/S has as its focus the needs of Canadian seniors today and in the future. Within the DAS/S there are four program elements: (a) Seniors Community Programs Funding — New Horizons (NH), Seniors Independence Program (SIP), Ventures in Independence, New Horizons: Partners in Aging (NH:PA) Funding; (b) Seniors Independence Research Program (SIRP); (c) policy coordination and support to the Minister; and (d) support to the National Advisory Council on Aging (NACA). While it is the responsibility of the Division of Aging and Seniors to implement the Seniors Strategy, it is assisted in this task through the activities of its partners: the Health Promotion and Programs Branch Regional Offices, the Extramural Research Division, NACA and the Health Policy Directorate.

The study was undertaken using multiple lines of evidence which, together, addressed each of the 13 evaluation questions identified for this exercise. The data collection methods used were the following: a review of the literature (including international literature) and selected data bases (i.e., General Social Survey, Ageing and Independence, Elder Monitor); a review of 341 project files (the majority from Seniors Community Programs Funding, but also from SIRP, NACA and internal projects); 119 key informant interviews with representatives from central agencies, Health Canada personnel, the Interdepartmental Committee on Seniors Issues, NACA, provincial/territorial governments, stakeholders, funding recipients and non-funded applicants; a survey of intended beneficiaries of funded community projects(n=553); a survey of general public clients of the Division of Aging and Seniors (n=301); three questions on a larger general public survey called *Rethinking Government* (n=2,962); and consultations with experts (n=7).

Although the evaluation was somewhat limited by its reliance on third-party opinion with no direct measure of impact (such as would have been obtained if an experimental design had been used) and the constraints under which the file review was conducted (e.g., limited time, some projects were still ongoing, not all documentation requested was available for all projects, some information was not stated explicitly in the files), several conclusions, as indicated below, can be drawn from the evidence.

Overall, the evidence collected for this study suggests that the DAS/S is addressing its long term strategic directions and short term goals and has successfully met some of these goals (e.g., increased knowledge on aging and seniors' issues, guided the development of innovative projects (i.e., NH:PA, SIRP), improved the mental well-being of seniors). Given the evolutionary nature of seniors programs at Health Canada (NH was initiated in 1972) and the short time period in which DAS/S has been in existence (since 1994), the success of the DAS/S to date is notable. Nevertheless, a number of suggestions for improvements to the DAS/S were provided during the consultations and are documented within this and earlier technical documents.

Program Relevance

Persistence of Risk

Despite advancements made in some areas (e.g., the public pension system), seniors in Canada still find themselves in situations of potential risk. According to the literature reviewed for this study, these conditions of risk are exemplified by the following needs:

- ☐ the poverty rate of seniors is still higher than that of the Canadian population as a whole (19 per cent versus 16 per cent for Canadians combined) (Lochhead and Shillington, 1996);
    - this is exacerbated by the fact that so many seniors are just above the poverty line (Health Canada, 1994a) making them ineligible for programs aimed at seniors living in poverty
- ☐ health care needs of seniors continue to be extensive;
    - seniors experience more health problems than those between 50 and 64 years of age (Synergistics Consulting, 1996)
    - seniors are hospitalized more often than middle-aged adults for most kinds of illnesses (Statistics Canada, no date on document)

  - estimates of how much seniors cost the Canadian health care system - range from 20 per cent to 50 per cent of health expenditures (National Advisory Council on Aging, 1994) — it has been noted, however, that the majority of costs occur in the last six months of life and are not spread over all senior years (Roos, Shapiro and Roos, 1984; see also Health Canada, 1994a)

- ☐ seniors require more assistance with daily living as they age; and
  - seniors 80 years of age and over tend to need help with housework (50 per cent) more than seniors 65 and over (36 per cent) (Statistics Canada, 1991b)
  - seniors 80 years of age and over are more likely to need assistance with preparing meals (33 per cent) than seniors age 65 or more (26 per cent) (Statistics Canada, 1991b)
  - seniors 80 years of age or more are more likely to need assistance getting around (i.e., transportation) (49 per cent) than are seniors 65 and over (33 per cent) (Statistics Canada, 1991b)

Health care and income security were also noted as the primary needs of seniors by interview respondents as well as survey respondents. Regardless of the above conditions, many respondents feel that the aging of the population in and of itself justifies the existence of a federal government unit responsible for addressing aging and seniors issues in order to prepare the ground for tomorrow.

Comparison With Other "At Risk" Groups

A comparison was undertaken of seniors and other "at risk" groups to determine whether seniors were any more at risk than other groups and whether their situation warranted a special focus. The review of the literature revealed that, overall, seniors are at least as "at risk" as some other "at risk" groups (e.g., children). While it appears from the evidence presented that Aboriginals are more "at risk" than seniors, it is important to keep in mind that it was not possible to draw direct comparisons between the two groups with the resources utilized in this study.

- ☐ Children:
  - at 18 per cent, the poverty rate of children under 15 is lower than that of seniors (19 per cent) (Lochhead and Shillington, 1996) — although the difference between the two rates is not drastic, of significance is the disproportionate number of seniors who are barely over the poverty line (Health Canada, 1994a);
  - seniors experience more illnesses than do children (Synergistics Consulting, 1996);

  - health service utilization in terms of visits to a medical doctor and institutionalized nights is higher among seniors (69 per cent had three or more visits in previous 12 months and 18 per cent spent three or more nights in hospital over the previous 12 months) than youth (three per cent and six per cent respectively) (Statistics Canada, 1991b);
  - young people are more likely to suffer from injuries (Statistics Canada, 1994-95) — injuries for seniors, however, tend to be more life threatening (Statistics Canada, 1992a); and
  - suicide rate of Canadian seniors is higher than that of Canadian youth (Royal Commission on Aboriginal Peoples, 1995).

- ☐ Aboriginals:
  - the economic situation of seniors is significantly better than that of Aboriginals (poverty rate for seniors is 19 per cent compared to the poverty rate of Aboriginals which sits at 30 per cent) (Lochhead and Shillington, 1996);
  - Aboriginal seniors have a lower suicide rate than non-aboriginal seniors (Royal Commission on Aboriginal Peoples, 1995); and
  - health statistics show that Aboriginal seniors are more at risk than their non-Aboriginal counterparts (Department of Indian Affairs and Northern Development (DIAND), 1989).

- ☐ Immigrants and Visible Minorities:
  - the poverty rate of visible minorities (27 per cent) is significantly higher than the poverty rate for seniors (19 per cent) (Lochhead and Shillington, 1996);
  - the prevalence of chronic conditions and long-term disabilities are no greater for immigrants than they are for the Canadian-born population (Chen, Ng and Wilkins, 1996); and
  - there is no indication that the health care needs of immigrants are not being met (Chen, Ng and Wilkins, 1996).

"At Risk" Senior Groups

Although all seniors are exposed to health problems, certain sub-groups of seniors were found to be more at risk than others:

- ☐ as health is directly related to income (Baker, 1988), there is no doubt that seniors with limited income (usually senior women as 38 per cent live below the poverty line [National Advisory Council on Aging, 1993e] and 60 per cent earn less than $20,000 a year [Statistics Canada, 1991b]) constitute a major segment of seniors at risk;

- although they represent less than one per cent of the population, health statistics still show that Aboriginal seniors are more at risk than non-Aboriginal seniors (DIAND, 1989); and

- seniors living in isolated or rural areas are also considered at risk because they have less access to services, especially public transportation services (National Advisory Council on Aging, 1993h).

The Role of Health Canada

While seniors have a number of specific needs, as illustrated by the above discussion, the two most important needs identified in the study were health followed by income security. The identification of these two issues as being of highest priority is not only supported by the literature and interview respondents, but also by the three surveys conducted as part of this study. In the survey of intended beneficiaries, 44 per cent identified health care and chronic illness as the main issue threatening the health, well-being and independence of Canadian seniors, with 26 per cent identifying income security. This same outcome was also seen in the results of the survey of general public clients: 57 per cent identified health care and chronic illness as the main issues followed by income security which was identified by 42 per cent. In the *Rethinking Government* survey, 44 per cent of respondents identified health care as being the most important need of seniors followed by financial security which was identified by 35 per cent.

Given the importance placed on health care by study respondents, as well as in the literature, it is important to review Health Canada's mandate in this area in order to determine how it can assist seniors in this areas. The *Department of Health Act* (Bill C-95), recently passed by Parliament, (July 19, 1996) outlines the role to be played by Health Canada with respect to the health of Canadians. Some specific responsibilities as outlined in the *Act*, and which are consistent with Health Canada's role within the DAS/S, are as follow:

- the promotion and preservation of the physical, mental and social well-being of the people of Canada;

- the protection of the people of Canada against risks to health and the spreading of diseases;

- investigation and research into public health, including the monitoring of diseases; and

- cooperation with provincial/territorial authorities with a view to the coordination of efforts made or proposed for preserving and improving public health.

Health Canada's role, as described in the *Health Canada 1995-96 Estimates, Part III*, is to help Canadians maintain and improve their health. The emphasis is on fostering healthy individuals, healthy families and a healthy society, with an emphasis on disease prevention and health promotion. The work of the Department includes:

- financial support to provinces and territories for insured health care;
- cooperation with provinces and territories in health system renewal and in addressing identified health-related issues;
- health protection and consumer safety by refocussing and strengthening Canada's health intelligence network;
- the fostering of public health research;
- activities aimed at improving health care and health services in Canada;
- activities aimed at disease prevention and the promotion of good health; and
- activities targeted at issues affecting specific groups in society (e.g., women, children, seniors).

The activities of the DAS/S are clearly relevant to the Department's legal mandate, as described above, as well as its overall mission — to help the people of Canada maintain and improve their health. Aspects of the DAS/S are also directly related to specific Departmental goals, as stated in the *Health Canada 1995-96 Estimates, Part III* — for instance, to foster active health system partnerships with provinces/territories and others; to give increased priorities to initiatives that redress the most significant health inequalities in Canada; and to provide leadership on health promotion, disease prevention and health strategies.

The identification of income security as the second most important need of seniors by study respondents, however, has resulted in a debate over who should be responsible for seniors programs. In other words, is Health Canada the best location for a program such as DAS/S? The question of who is responsible for seniors programs at the federal level has only become an issue since National Health and Welfare Canada was divided and the responsibility for income security programs (i.e., Canada Pension Plan (CPP), Old Age Security (OAS), Guaranteed Income Supplement (GIS)) and the cost sharing of welfare programs (i.e., through the Canada Assistance

Plan) was transferred to Human Resources Development Canada (HRDC). This has resulted in some respondents feeling that perhaps HRDC would be better positioned to take the lead. Most respondents, however, felt that given the focus on health needs, this role should rest within Health Canada. Also, Health Canada's adoption of a health determinants approach which recognizes the importance of income security on health, makes not having income security programs located in Health Canada less of a crucial factor. Finally, it makes sense for Health Canada to continue to lead the federal government's efforts on seniors' issues: it has the legal mandate (as already noted) with responsibilities for the promotion and preservation of the well-being of Canadians, the necessary experience and expertise and has assumed a leadership/coordination role between different departments and different levels of government. What this division does mean, however, is that it will be important for Health Canada and HRDC to work closely together to coordinate their efforts with Health Canada taking the lead in this activity.

Respondents views regarding the appropriate role for Health Canada varied somewhat (e.g., delivery of community funding programs versus the funding of research). Notwithstanding these variances in opinion, however, a number of key roles for Health Canada were discerned. These roles, as discussed below, can be characterized as macro-management.

Policy and Leadership

Health Canada is perceived to have a very important role in setting of national standards, developing of national policies and legislation and providing a broad national perspective on seniors issues. This role is considered to be important to ensure that seniors across Canada have access to the same services and the same quality of services. It was also felt that Health Canada had an important leadership role to play in addressing aging and seniors issues.

Coordination

Coordination between different departments and different levels of government as well as with NGOs is seen as a crucial role for Health Canada. Given the size of the country, provincial/territorial responsibilities for health care and the fact that other federal government departments also address seniors issues, effective coordination is absolutely essential to ensure activities are not duplicated. This role is even more essential to the success of Health Canada's operations now that it is pursuing a population health strategy approach and a broader health determinants model. The Interdepartmental Committee on Seniors Issues and the federal/provincial/territorial meetings are two ways in which Health Canada pursues the coordination of activities between different departments and different levels of government.

Information Sharing

There was general agreement that Health Canada has a key role to play in terms of ensuring that information (e.g., research results, lessons learned from community projects, issues) is well-disseminated to all areas of the country as well as to all interested parties (e.g., organizations, seniors themselves). As the dissemination of information across the country is a tremendous undertaking, Health Canada was viewed as well positioned to play a facilitative role in helping everyone concerned with seniors issues to effectively receive and disseminate information.

Health Promotion and Disease Prevention

Given the acknowledged benefits to society of prevention activities in all sectors (e.g., health, crime), it is not surprising that prevention was seen by respondents as being an important role for Health Canada. This importance was emphasized by a few respondents (e.g., one provincial/territorial government respondent) that provinces/territories have other priorities to address and have cut back on preventive measures. As a preventative measure, health promotion was also identified as a key role for Health Canada as it was believed by some Health Canada respondents in Ottawa that no other level of government or department was involved in the promotion of health and disease prevention at the national level.

Champion of Seniors and Aging Issues

It was felt by respondents that Health Canada is well positioned to act on behalf of seniors as an advisor to the federal government and to raise the awareness of other departments as well as different levels of government on issues concerning seniors.

Duplication or Overlap

Evidence gathered for this study indicated that, overall, the DAS/S is meeting a unique need as little duplication or overlap was noted by respondents. While some occasional duplication with provincial/territorial programs that fund projects was noted by some provincial/territorial government representatives, these respondents generally felt that DAS/S activities complemented those undertaken by their governments. The successful lack of duplication is considered to be the result of the DAS's coordination activities. Duplication that does exist is seen to be the result of some communication gaps (e.g., flow of information between levels of government as to funding priorities) between federal and provincial/territorial authorities at the regional level.

Program Accomplishments

Program Delivery

Participants in the general public survey as well as funding recipients and non-funded applicants were asked to comment on DAS/S's program delivery. Overall, both survey participants and respondents viewed the delivery of DAS/S activities positively, with general public clients being the most satisfied. More specifically, of the general public clients:

- ❑ 90 per cent indicated they had obtained the information for which they were looking;
- ❑ 80 per cent indicated the contact had met their expectations;
- ❑ over 80 per cent expressed satisfaction with the clarity, relevance and usefulness of the information, publication or advice received;
- ❑ between 70 and 77 per cent were satisfied with the program's promptness, understanding of their request and ability to deliver on their request; and
- ❑ about 60 per cent were satisfied with the willingness of staff to go the extra mile.

Overall, funding recipients and non-funded applicants were satisfied with the application and approval process as well as most administrative procedures and requirements. Funding recipients (both community funding programs as well as SIRP) were particularly pleased with the support they received from both regional Health Canada personnel as well as the staff at the national office. Complaints that were received focused on the short timeframe for completion of the application, the slow process of obtaining funding and the short timeframes allowed for project start-up.

Coordination Activities

As already noted, coordination is seen to be a very important role for Health Canada to play and steps have been taken by the DAS/S to facilitate coordination. Most notably, in 1994, the Interdepartmental Committee on Seniors Issues was created and work to establish a Framework on Aging was undertaken. It should be noted, however, that the first step to improve the coordination of seniors programs was the creation of the Seniors Directorate in April 1994. The Directorate was mandated to act as a focal point on seniors and aging issues within both Health Canada and the federal government. There is also ongoing liaison between Health Canada regional personnel and their provincial/territorial counterparts, especially in the area of consultation in the approval process for community projects. Opinions as to how successful the DAS/S has been in coordinating activities, however, is somewhat mixed. In terms of coordination between Ottawa and the regions, Health Canada Regional personnel feel there is a need for improvement both in coordination and communication. Provincial/territorial government representatives support this view indicating that, although coordination between Health Canada and the provinces/territories is good, there is need for further efforts to be taken (e.g., have more input from provinces as to which projects are funded).

Partnerships

DAS/S's accomplishments at partnership development have not gone unnoticed by respondents. In terms of community funding projects, partnership development is particularly evident in New Horizons: Partners in Aging (NH:PA) and Ventures projects. Partnerships tended to be primarily with seniors organizations and other Non-Governmental Organizations (NGOs). Given that partnership development was a requirement of these programs, this finding is not surprising. Regardless, partnerships have played an important role in community funding projects and have led many projects to at least see self-sufficiency as a goal: for example, 71 per cent of the New Horizons projects reviewed for the file review indicated either being self-sufficient or at least planning on being self-sufficient (due to the apriori nature of this information, it is difficult to determine exactly how many achieved self-sufficiency)[1]. This achievement of self-sufficiency is also supported by funding recipients who were interviewed as part of this study: many of the completed projects were self-sufficient, although the activities for some were scaled down, and those projects that were still ongoing were optimistic that they would secure funding for continuation. Partnerships have also been key components in SIRP and NACA projects. While respondents noted the efforts of DAS/S to develop partnerships, there is the feeling that more could be done, specifically with the private sector.

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[1] A smaller proportion of projects from the other programs indicated self-sufficiency (i.e., SIP — 28%; Ventures — 38%; NH:PA — 21%). This is partly due to a lack of information on self-sufficiency in the documents reviewed (e.g., only 9 out of 42 NH:PA projects had information on this issue).

Achievement of Objectives and Intended Impacts

It is somewhat difficult to comment on the impacts and effects of the DAS/S given the many changes that have occurred over time which have resulted in some programs in the evaluation being relatively new (e.g., NH:PA) and others having had different requirements from the current programs (e.g., New Horizons). As well, no direct measure of impact was undertaken (i.e., there was no pre and post program measures). Nevertheless, study findings indicated that some objectives have been achieved, at least in part, and various impacts have been noted. These included:

- ❑ targeting seniors "at risk" has been observed in more recent projects. Between 1991 and 1995, Seniors Community Programs funding generally benefitted healthy, active and financially secure seniors. Evidence from the review of project files as well as the survey of intended beneficiaries, however, indicate that NH:PA projects have been more successful at targeting "at risk" seniors (as this is a requirement of NH:PA, this finding is not surprising);
- ❑ 74 per cent of intended beneficiaries indicated that the services they had received from community funding projects had had a positive impact on their health, well-being and independence;
- ❑ the impacts of community funding programs have been primarily at the level of mental well-being and social interaction;
- ❑ DAS/S's internal activities are considered to have had a positive impact on policy coordination and policy promotion — especially its organization of conferences, workshops and other fora — as well as having provided significant support for NACA;
- ❑ while there is speculation as to the extent to which information (e.g., reports, position papers, publications) is filtered down to individual seniors, the general perception is that SIRP and NACA have produced valuable results which have been transformed into widely disseminated information;
    - seniors who participated in the survey of general public clients indicated that the impact of their contact with DAS/S was increased awareness in specific areas (e.g., nutrition, physical exercise) and a facilitated ability to disseminate accurate information to others

- ☐ Ventures in Independence has successfully developed partnerships as per its program objectives;
- ☐ the current criteria of innovation and collaboration is being applied in NH:PA projects as well as SIRP and NACA — SIRP and NACA in particular are considered to have fostered important and unique (e.g., multidisciplinary) collaboration and partnerships;
- ☐ overall, the activities of SIRP (by allowing researchers and policy makers from different parts of the country to work together) and NACA have had an impact on policy, although the direct impact of NACA on policy is less certain, and have advanced the state of knowledge about aging and seniors issues;
- ☐ it is acknowledged that SIRP has been successful in getting critical research undertaken and fostering the sharing of information; and
- ☐ NACA's key strength is considered to be the quality and popularity of its publications.

Strengths

There was overall agreement that one of the key strengths of DAS/S was its staff. DAS/S staff are considered by respondents to have a high level of expertise and experience, to be knowledgeable and highly committed to seniors/aging issues. Other strengths of note include:

- ☐ ability to raise the profile of seniors issues;
- ☐ providing leadership to other federal departments;
- ☐ funding for seniors activities which allowed many projects to be undertaken;
- ☐ involving seniors in funded projects; and
- ☐ producing publications on seniors issues that are readable, relevant and well distributed.

Weaknesses

There were three major weaknesses of the DAS/S noted by respondents: (a) aspects of the funding process for community projects (i.e., lack of overall funding, lack of on-going funding, lack of funding for long-term projects); (b) profile (lack of profile of DAS/S — e.g., its activities, its mandate); and (c) co-ordination and communication (i.e., between Health Canada in Ottawa and Health Canada in the regions, between Health Canada and provincial/territorial governments, among federal government departments). Of note is that DAS/S's coordination activities were cited earlier as having been key to the successful lack of duplication of programs and activities. Nevertheless, study respondents also stated that this was an areas of weakness. The perceived weakness in co-ordination and communication is particularly noteworthy given that this is considered to be one of the key roles for Health Canada. Other weaknesses noted by respondents include:

- ☐ the process for applying for funding (e.g., slow, requirements are too restrictive);
- ☐ lack of progress in drawing lessons learned from activities, particularly community funded projects;
- ☐ lack of an evaluation strategy for projects; and
- ☐ lack of synthesis in the area of research.

Alternatives

Cost-Effectiveness

It is difficult to comment on the cost-effectiveness of DAS/S's programs as there is little hard evidence which examines the relative cost-effectiveness of the different elements or approaches of DAS/S. For example, the information kept in the project files does not allow an analysis of costs and benefits. Efforts have been made, however, by the DAS/S to ensure the cost-effectiveness of activities at the front-end of many projects by, for instance, ensuring the project is needed, innovative, involves partnerships and funded according to established priorities. Most respondents were also unable to comment on the cost-effectiveness of the various DAS/S programs. Respondents, however, generally believe that DAS/S's approach — to foster the health, well-being and independence of seniors — should lead to activities being cost effective. Additionally, respondents indicated that independence and high quality of life have important, positive implications for health care costs and can decrease the expenditures on health and social services. According to the literature (Baker, 1988), it has been suggested by many authors that major reforms resulting in a renewed focus on prevention, community and home care, and the use of a variety of practitioners will prove to be cost-effective. For example, self-help and self-care are low cost strategies which can improve health and living conditions.

Essential Areas for DAS/S Involvement

Generally speaking, respondents felt that DAS/S should stay involved in all areas in which it is currently involved. The importance of maintaining a division on aging and seniors issues was also noted by many respondents. Specific areas identified by respondents as being essential for the DAS/S to retain closely mirror the roles identified as appropriate for the federal government and Health Canada to play in terms of seniors and aging issues. These areas are as follow:

- ☐ *policy* — developing and guiding policy at a national level;
- ☐ *coordination and facilitation* — coordinating seniors programs and activities both within the federal government and across other government jurisdictions and non-government organizations;
- ☐ *research* — playing the lead role in setting the research agenda, funding, coordinating partnerships and disseminating results;
- ☐ *information sharing* — consolidating information and disseminating it to provinces/territories, other organizations and to seniors themselves; and
- ☐ *funding of seniors community-based programs.*

In the surveys of general public clients and intended beneficiaries, very few programs and services affecting seniors were identified as areas where the government should reduce its support — the exception being out-of-country health care. In terms of increasing its support, non-seniors were more likely to feel the government should increase its support across a variety of areas than were seniors. There was, however, agreement among survey respondents (including those from *Rethinking Government*) that health issues are a priority. Both general public clients and intended beneficiaries identified funding for research on seniors' health concerns, care of seniors in the home, caregiver support and home care/home support services as areas where the government should increase its support.

Non-Essential Areas for DAS/S Involvement

Respondents in general, including survey respondents, were reluctant to identify any areas of DAS/S as being non-essential. This may be in part because many respondents indicated viewing the strategy holistically — it is an integrated program with each area benefitting from the others. Some respondents suggested withdrawing from community funding programs, although it was considered by others to be an essential area for DAS/S. The rationalization for this tends to be that this role really belongs to the provinces/territories and is not consistent with the current direction in which the government is moving. The federal role, it was felt, should be more appropriately focused on funding demonstration projects, evaluating them and disseminating results in order to promote the initiation of successful projects. This is consistent with Health Canada maintaining a research role in that it would be undertaking research on what types of programs work and disseminating these findings. Concern, however, over the inability of provinces/territories to take on the financial responsibility for community funding programs was raised by some respondents. Other areas identified as non-essential, albeit with less frequency, include:

- ❑ public image-related projects;
- ❑ projects outside the "bread and butter" concerns of the DAS/S or which are perceived to provide little value for money; and
- ❑ areas not strictly related to health (e.g., poverty, unemployment).

Alternative Program Mechanisms and Structures

Respondents had very few recommendations for new or alternative program mechanisms and structures for DAS/S with many feeling that the Division should be retained as is. That said, a few suggestions or recommendations were made:

- ❑ devolve responsibility for community funding programs — while some respondents felt the responsibility for community projects should be given to the provinces/territories, it was noted (particularly by the provinces/territories) that the funding would still have to come from Health Canada;
- ❑ improve the organizational location of DAS/S within the department as currently it is too far removed from the Deputy Minister/Minister to have an impact on policy;
- ❑ shift some DAS/S program resources to internal operations to permit greater policy development; and
- ❑ explore alternative, more cost-effective methods of communication.

Improvements

A number of suggestions for improving DAS/S were provided by respondents. Although suggestions varied, some common themes emerged:

- ☐ ***coordination*** — ensure greater coordination of programs across the federal government and between the federal government and provincial/territorial governments;
- ☐ ***planning*** — incorporate a longer-term, more planned view in terms of funding decisions and allocations for community projects;
- ☐ ***partnership*** — establish more partnerships with external organizations, specifically private sector; and
- ☐ ***evaluation*** — rigorous and realistic objectives should be developed with the current conceptual approach to seniors and aging issues being translated into measurable operational objectives. This would enable an evaluation strategy to be implemented to assess various elements of the strategy or projects funded by the programs at the project-level.

Conclusions

Perhaps one of the most important conclusions to be drawn from the evaluation of the Division of Aging and Seniors/Seniors Strategy is that the federal government, and DAS/S in particular (whether as a separate unit or within the Population Health Strategy), continues to have a relevant role in addressing aging and seniors issues. The general feeling is that, while the situation of seniors has improved with many of their issues being addressed, still more needs to be accomplished. The specific roles identified by respondents for the federal government and DAS/S include policy and leadership, intra and intergovernmental coordination, information gathering — including research — and dissemination, health promotion and disease prevention, and an champion of seniors and aging issues role. These roles correspond very closely to those areas identified by respondents as essential areas for DAS/S involvement.

Respondents expressed overall support for DAS/S's various programs and activities, indicating that the activities had, at least to some extent, improved the health, well-being and independence of seniors. Study findings also suggest that a number of the objectives of the programs are being met (e.g., innovation, targeting, partnership development). SIRP and NACA were also considered by respondents to have been successful at producing high quality research and at disseminating this information to policy makers, researchers and stakeholders. Suggestions for improvements to DAS/S were provided by respondents. These suggestions include: improved coordination; better planning; more partnerships; and development of measurable operational objectives which would enable an evaluation strategy to be implemented that would allow for project-level evaluations. It was also suggested that the Seniors Community Programs Funding could perhaps be devolved or its funds re-oriented towards demonstration projects. It should be noted that some of the issues noted in the evaluation had already been identified by the DAS/S and, in recent years, have begun to be addressed.

CHAPTER

1 INTRODUCTION

1.1 Introduction

This document is the Final Report submitted to present the results of the evaluation of the Health Canada Division of Aging and Seniors/Seniors Strategy (DAS/S). The organization of the report is described in Section 1.4. In this chapter, the context for the study, including a discussion of the history of the DAS/S and its program elements, and the evaluation issues are presented.

(a) Context

Demographers, social scientists and others have devoted increasing attention in recent years to the interplay among factors such as fertility and mortality rates and migration and the effect of these factors on the age structure of society. It is now common wisdom that the Canadian population, like other western countries, is aging. In short, this means a greater portion of the population in Canada falls into the over 65 years age category than ever before. This trend is expected to continue as the "baby boom" generation moves into their senior years and because fertility and immigration rates remain low. The composition of the older age category has also shifted. Canadians are living longer, meaning that the proportion in the oldest age category (e.g., over 75 or over 85) has increased dramatically (Desjardins, 1993).

The numeric changes in terms of the number of seniors in Canada has also been accompanied by a shift in the social profile of seniors. Research and consultations with seniors have suggested that previous stereotypes of seniors seem no longer valid for increasing numbers of individuals over 65 years of age (National Advisory Council on Aging, 1993b). Seniors are healthier, more active and more vocal than ever before. Tomorrow's seniors are likely to be even more highly educated and, some, more affluent. Seniors report less stress in their lives and more time to do some of the things they were unable to when kept occupied by jobs and child-rearing. In general, seniors' views about aging reveal a primarily positive outlook on life (Tandemar Research Inc., 1988).

While seniors indicate that they usually meet with positive attitudes and respect from other people, in some quarters there continues to be naive or negative attitudes and images about aging and seniors (Desjardins and Dumas, 1993). Some analysts have hypothesized that the increased number of seniors in today's society makes their position somewhat trivialized, and the disadvantages which accompany any physical and mental deterioration seem to outweigh the knowledge and experience they have accumulated throughout their long lives. Seniors themselves feel that additional public awareness work is necessary to counteract the minority still holding ageist views and attitudes (Desjardins and Dumas, 1993).

These demographic and social realities pose challenges for governments as well as the social and health organizations serving seniors who will need to respond to the changing needs of society. The aging of the population is expected to have a widespread impact on policy and on the political agenda as the focus shifts toward the needs of seniors. While many seniors live independently, relying on personal networks and support, the aging population will place different, and some say increased, demands on current institutions. These institutions provide the support for seniors to live independently and provide direct services for those who cannot. Implications for health care, income security, social service assistance and housing are anticipated. Public awareness, image and rights of seniors will also be prominent issues in the future.

(b) Profile of Canadian Seniors

Seniors are not an homogenous group and their experiences of aging and old age are linked to social, economic, epidemiological and demographic characteristics. Research has indicated that health and independence are key considerations for seniors in assessing quality of life. Good health and independence are very much linked (Optima Research, 1991). For example, the loss of independence as a result of a stroke, broken bones or general physical deterioration is a key concern of many seniors. In other research (Tandemar Research Inc., 1988), seniors interpreted independence as making one's own decisions, having control over where one will go and what one will do, and as being related to dignity, pride and being happy. Having a positive attitude and focusing thoughts on the good things about their lives (e.g., friends, activities they are able to enjoy, family, etc.) was also considered by seniors to be an important component of leading a satisfying life after 60.

The general demographic profile of seniors has changed in the last several decades and is expected to continue to shift in the future. Following is a brief profile of Canadian seniors.

Age. In 1991, 31 per cent of the Canadian population was aged 45 or over and 12 per cent was aged 65 years or more (Statistics Canada, 1993a). While the proportion of Canadians aged 65 and over has been growing since the turn of the century, the pace has increased significantly in the last few decades, and is expected to continue to increase in the future. For example, the proportion of the total population aged 65 and over was approximately 5 per cent around 1900, 6.7 per cent in 1941, 9.7 per cent in 1981, and is expected to exceed 19 per cent by 2021 (Gee and Kimball, 1987). At the same time, the senior population itself is aging: the number of Canadians aged 75 or more grew at an annual rate of 3.5 per cent or more throughout the 1980's, compared to a rate of about 1 per cent for the rest of the population, and this rate is expected to be maintained to the end of the century (National Advisory Council on Aging, 1989).

Gender. Women make up a larger and larger proportion of older age cohorts. For example, in 1991, there were 1.38 women for every man in the 65 and older group and 2 women for every man in the 85 and older group (National Advisory Council on Aging, 1993d). One researcher has noted that the experience of old age can be very different for men and for women, assuming that gender differences over the life course also influence the daily lives of seniors (Barer, 1994). For example, women were traditionally encouraged to be more passive and family oriented, something which does not change for many women as they age. On the other hand, male roles tend to emphasize competence, activity, productivity, independence and self-reliance. These orientations, however, become more and more difficult to maintain as one ages.

Residence. With respect to geographic location, 75 per cent of all seniors lived in Ontario, Quebec and British Columbia in 1991, mirroring the general population distribution. Victoria had the highest percentage of seniors (19 per cent) and Calgary had the lowest (8 per cent) (National Council on Aging, 1993f). Most seniors live in the community (94 per cent), with only 37 per cent of those 85 and over living in institutions (National Advisory Council on Aging, 1993i).

Income. Exclusion from the labour market and a lack of pension income place a significant minority of Canadian seniors in a position of near-poverty or poverty. For example, in 1990, 35 per cent of unattached seniors had incomes placing them below the federal government's poverty line. Unattached senior women were more likely than unattached senior men to be poor (38 versus 26 per cent) (Ng, 1992). Living under these financial pressures can add significant strain to the experience of old age.

Health. Seniors suffer from a number of common health problems, including: arthritis-rheumatism (55 per cent); hypertension (39 per cent); and respiratory difficulties (24 per cent) (National Advisory Council on Aging, 1993c). They are also twice as likely to report these health problems than the total population. However, although 80 per cent of seniors report one or more chronic conditions, only 20 per cent report that these conditions have limited their activities in a major way. Seniors are also living longer. Between 1975-77 and 1985-87, the life expectancy of men at the age of 65 increased from 14 to 14.9 years and the life expectancy of women increased from 18 to 19.1 years (National Advisory Council on Aging, 1993c).

Education. Seniors are becoming increasingly more educated as society is becoming more educated. In 1986, 27 per cent of seniors over the age of 65 had graduated from either high school or a post-secondary educational institution. It is believed that by 2006, this will have increased to 37 per cent. Seniors are also more involved in adult education. For example, participation in educational activities organized by Creative Retirement Manitoba has increased from 200 in 1980 to 3,000 in 1991. In fact, it has been estimated that participation in adult education will increase by 94 per cent by 2005 and by 141 per cent by 2010 (National Advisory Council on Aging, 1993a).

Ethnic and Racial Issues. In Canada, approximately 16 per cent of seniors were born outside Canada and approximately 27 per cent reported an ethnic origin other than British or French (1981 data) (National Advisory Council on Aging, 1993g). According to Henderson (1994), the multiple statuses of advanced age, ethnic-minority membership and health failure can combine to create a vulnerable late life experience. For example, very old ethnic-minority elders may still experience the effects of prejudices while they personally are at their peak lifetime experience of financial and health difficulties. Conducting research with ethnic-minority seniors is complicated by variation in the degree to which these individuals have acculturated and by the degree to which they choose to reveal personal cultural differences to the researcher. In some circumstances, ethnic-minority seniors may prefer to conceal cultural differences while in others they may feel comfortable revealing these distinctions.

It is commonly believed that elders in some ethnic groups have fewer concerns about their well-being as they are taken care of by their families. Interestingly, some researchers dispute the commonly-held belief that "traditional" ethnic groups show different family support patterns for seniors than more "modern" ethnic groups (Payne and Strain, 1991). In their analysis, no clear pattern of differentiation between traditional and modern ethnic groups exists in terms of family support patterns. Similarly, even the age at which a person is considered old may vary as a result of groups: for example, one author recommends that Aboriginal Canadians be considered elderly once they are 50 years of age or older, to reflect different life expectancies, and morbidity and disability levels (Armstrong-Esther, 1994).

A source of stress in some ethnic seniors may also arise from the juxtaposition of their cultural heritage, in which the elderly are held in high esteem, with the reality of Canadian society where they may feel a lack of respect for their position (National Advisory Council on Aging, 1991b). Recent research conducted in

Manitoba does suggest, however, that the atmosphere for the elderly may be improving or, at least, that seniors in some ethnic groups (especially English, French and German) themselves perceive it to be improving (Chipperfield and Havens, 1992). A related stress concerns the need for seniors to also adapt to and be tolerant of demographic changes including immigration and assimilation of members of visible minorities.

The Federal Government's Response

The first federal programs targeting seniors were in the area of income security (e.g., Old Age Pension was introduced in 1927, which became Old Age Security (OAS) in 1952; Canada Pension Plan (CPP) was established in the 1960s). In 1972, the then Department of Health and Welfare created the New Horizons program. The awareness of Canada's aging population had resulted in increased concern over the rising costs of institutional care and the greater demand for services by and for retired persons (National Health and Welfare, 1988). The purpose of New Horizons was to fund projects that were not only more meaningful and beneficial to older, retired Canadians and their communities, but were also managed and delivered by them. In 1980, the Minister of Health and Welfare established the National Advisory Council on Aging (NACA), based on a recognized need for independent advice and research on seniors' issues and related issues on aging (Health Canada, 1995d). As an independent body, the purpose of NACA was to assist and advise the Minister on all issues of concern to seniors. Seven years later, in recognition of an aging population, a Minister of State for Seniors was appointed.

Falling on the heels of the appointment of the Minister of State for Seniors, a five-year Seniors Initiative (also referred to as the Seniors Strategy) was announced six months later (February 1988). In addition to increasing the funding for the New Horizons (NH) program and the financial support for NACA, funding was provided for the Seniors Independence Research Program (SIRP) and the Seniors Independence Program (SIP). Under the Seniors Strategy, SIRP had as its mandate the conduct of research on diseases (e.g., Alzheimer's) that inhibit seniors' independence and their quality of life. With the second Strategy (discussed below) the mandate and objectives of SIRP were renewed with an additional objective to strengthen and develop national research initiatives with a balanced emphasis on social, economic and health determinants of independence for both today's and tomorrow's seniors. SIRP research funding was (and is) administered by the National Health Research and Development Program (NHRDP). While within Health and Welfare Canada, SIRP also funded some research through the Welfare Grants Division[2]. At this point, the former Aging-Related Diseases Division in the Laboratory Centre for Disease Control (now the Aging-Related Diseases Program in the Division of Aging and Seniors) was part of SIRP. The purpose of SIP was to provide funding which would facilitate partnership building between the voluntary sector and seniors for the purpose of developing innovative approaches to support seniors' independence and their quality of life.

Finally, a Seniors Secretariat was created to provide support to the Minister of State for Seniors as well as to consult with other departments, provincial/ territorial governments and Non-Governmental Organizations (NGOs) for the purpose of sharing information, sponsoring meetings and workshops and developing publications. In addition to the above, financial support was also provided to the Health Policy Division[3] to enable the provision of analysis, advice and information to the Minister of Health and Welfare and the Minister of State for Seniors on health, social and policy issues related to seniors. Although these components all fell under

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2. The National Welfare Grants (NWG) Division went over to Human Resources Development Canada in June 1993.

3. Following a reorganization in 1995 in the Policy and Consultation Branch, the section of the Health Policy Division which was responsible for seniors issues became the Health Economics and Systems Analysis Division.

the Seniors Initiative, they were all separate entities and were dispersed throughout the Department.

In 1993, the Seniors Strategy was renewed by Cabinet for another five year period. By building on past achievements and through the introduction of new innovative elements, the renewed strategy was to lead to the enhancement of independence and quality of life for seniors. The Seniors Strategy received $170M in funding (later reduced by half)[4], which included $149M to be used for continued funding of seniors community programs, to be allocated over the five years. In addition to this funding, the renewed Strategy also had access to A-base funds allocated to New Horizons and NACA, making a total of $234M originally available to the Seniors Strategy and its component elements. In addition to the components that existed under the original Initiative, two new components were added to the strategy: the Ventures in Independence funding program and the development of a Federal Policy on Aging. Through Ventures in Independence, partnerships between seniors and business, labour and other levels of government were developed for the purpose of addressing issues on aging and independence. The Federal Policy on Aging was to be developed to support a comprehensive agenda for action on issues of concern to seniors now and in the future.

Since its renewal, there have been a number of events that have impacted on the new Seniors Strategy. Two months after its renewal, the government went through a restructuring which resulted in a re-mandated health portfolio, turning the focus of the Department onto the challenges facing Canada's health care system. It was also at this time that the Minister of State for Seniors was abolished, transferring the responsibilities over to the Minister of Health who then also became the Minister Responsible for Seniors. Finally in the fall of 1993, the *Report of the Auditor General of*

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[4] As a result of various review exercises within the Department.

Canada expressed a need for seniors-related activities to be coordinated and rigorously evaluated.

Following an internal review at Health Canada and taking into account the recommendations of the Auditor General's Report, a Seniors Directorate was created in 1994. This Directorate was later renamed the Division of Aging and Seniors (DAS) following a restructuring of the Health Promotion and Programs Branch in 1995. In addition, the majority of Health Canada's seniors programs, including the majority of the Seniors Strategy's components (i.e., Seniors Secretariat, the Secretariat to the NACA, Seniors Community Programs and some parts of the SIRP) were merged and placed under the Directorate's mandate. This, in effect, brought most of the advisory, policy, research, programming, communications, consultations and administrative functions of the seniors programs together into one organization. Responsibility for program delivery, however, was shared with or continued to be within the functions of elements that remained outside the Directorate with the capacity for specialized policy assistance still being maintained in the Policy and Consultation Branch. Through this merger, Health Canada gained control over the coordination of the elements contained under the renewed Seniors Strategy and, through the DAS, is better able to monitor the Strategy. While the Seniors Strategy was renewed with a five year mandate, it will sunset after four. Also, the Federal Policy on Aging which was to be pursued as part of the renewed Strategy was relinquished. This was replaced by the Framework on Aging developed under the aegis of the Ministers Responsible for Seniors (the Federal/Provincial/Territorial component) and the Interdepartmental Committee on Seniors Issues (the federal component).

In April 1995, within the Division of Aging and Seniors, New Horizons, the Seniors Independence Program and Ventures in Independence were amalgamated into the New Horizons: Partners in Aging (NH:PA) program, although administratively they had already been amalgamated under Seniors Community Programs in 1993. The

NH:PA now serves all applicant groups of the former three programs. With the creation of NH:PA, new program objectives (e.g., seniors at risk, innovation and evaluation, partnerships) and new program procedures (e.g., priority setting, solicitation, review) were formally introduced.

Not all elements of the Seniors Strategy were absorbed by the Division of Aging and Seniors. There are four organizations which, although they reside outside of the DAS, collaborate with the Division in delivering parts of the Seniors Strategy. These organizations are: the Health Promotion and Programs Branch Regional Offices (HPPBRO); the Extramural Research Division of the Research and Program Policy Directorate in the Health Promotion and Programs Branch; the National Advisory Council on Aging; and the Health Economics and Systems Analysis Division which is part of the Health Policy and Consultation Branch. The HPPBRO shares joint responsibility with the DAS for the delivery of seniors' community funding programs. The Extramural Research Division administers the SIRP, including the conduct of peer reviews and the management of finances for seniors research. The National Advisory Council on Aging, with research and secretariat support from the DAS, both sponsors and conducts research on issues related to aging as well as provides the Minister with advice on seniors issues. The Policy and Consultation Branch assists the Minister through research and analysis and the provision of policy advice on issues and activities such as federal/provincial/territorial health renewal.

For the purpose of this evaluation and to reflect the fact that the Division of Aging and Seniors and the Seniors Strategy are now interconnected, they are referred to as the Division of Aging and Seniors/Seniors Strategy (DAS/S). Not only are they connected, but the A-base and Strategy funding envelope are now considered within a single envelope. For 1995-96, the total budget for the DAS/S was $33,118,000. This budget is broken down by program in Table 1.1.

TABLE 1.1
Division of Aging and Seniors/Seniors Strategy Financial Resource Summary for 1995-96

Program Element	Operating Budget ('000s)	Grants and Contributions Budget ('000s)	Total Budget ('000s)	Percentage of Total Budget
New Horizons:Partners in Aging	$3,240	$18,000	$21,240	64.1%
Seniors Independence Research Program	$510	$4,345	$4,855	14.7%
Policy Consultation and Support to the Minister	$6,673	—	$6,673	20.1%
National Advisory Council on Aging	$350	-	$350	1.1%
Total for all Program Elements	$10,773	$22,345	$33,118	100%

1.2 The Division of Aging and Seniors/ Seniors Strategy

The Division of Aging and Seniors' primary responsibility is the implementation of the Seniors Strategy. This is achieved not only through its own operations, but also through the activities of its partners: HPPBRO, Extramural Research Division, National Advisory Council on Aging and the Health Economics and Systems Analysis Division.

(a) Objectives

Prior to the merging of the elements under the Seniors Strategy into one organization, each element had its own objectives. These objectives have since been reviewed and reinterpreted in light of the strategic directions of the DAS and are now incorporated and reflected in the Division's long-term strategic directions. Both the objectives and the long-term strategic directions were developed and introduced in 1994. The long-term strategic directions are (Health Canada, 1995d, p.7):

- ❑ *to improve and preserve the health, well-being and independence of seniors in Canada;*
- ❑ *to increase society's understanding and acceptance of aging and seniors; and*
- ❑ *to eliminate barriers to the involvement and participation of seniors in society.*

In order to effectively carry out this evaluation, some of the key concepts within these objectives had to be operationalized. Following are the definitions utilized for the research (particularly the file review):

- ❑ ***Health and Well-Being.*** A project was considered to address health and well-being if its activities were aimed at, for example, seniors with chronic illnesses, physical disabilities, mental-illness, socially isolated seniors and seniors' general health. For example, a meals-on-wheels program aimed at preventing seniors from falling into the "tea and toast" spiral by providing seniors with nutritious meals would be considered to address health and well-being.
- ❑ ***Independence.***[5] Defining independence separately from health and well-being was a challenge as the three concepts are so inextricably

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[5] It should be noted that the Division finds the definition of independence which was utilized to be very narrow. They find the definition fails to include the concept of autonomy and, consequently, does not allow evidence to be captured regarding independence within a nursing home or institutionalized setting. The use of this definition could result in findings (which indicate that community projects did not address independence) considered to have limited validity.

intertwined. The decision to separate independence from health and well-being was one that was strongly discouraged by the DAS during the design phase. We felt, however, that some delineation was important to attempt in order to be able to discuss differences among the various funded projects. Wanting to separate the concept of independence, however, necessitated that a definition be developed. The Division of Aging and Seniors and Seniors was asked for a definition of independence, but, as they do not separate the three concepts, felt unable to respond to our request.

There is not a simple definition of independence as it refers to seniors. According to the Conceptual Framework for the Seniors Community Programs (Health Canada, 1993), seniors independence is a continuing process involving a balance between self-reliance, interdependent relationships and support from others. Additionally it involves the right to make choices, act on one's own behalf and be involved in decisions affecting oneself. Another report indicated that seniors independence requires ensuring: the necessities of life, including adequate income, access to health care and housing; access to work or income generating opportunities; timely access to community support services; access to education and training programs; and access to health promotion/illness prevention activities (Cambium Consulting, 1991). Not all aspects of the above definitions/requirements can be easily operationalized. It was still important, however, to develop a definition to ensure this concept was being treated consistently by the analysts.

It was finally decided that a project would be coded as addressing independence if its activities were aimed at enabling seniors to remain within the community by, for example, not only having services and activities available but also by having them be accessible (e.g., through transportation). This definition provided analysts with a mere guideline. Additionally, inherent in the word "independence" is "lack of dependency". Consequently, projects whose activities were clearly aimed at reducing a senior's dependency would also have been coded as addressing the issue of independence. For example, a project in which volunteers assisted seniors with their grocery shopping would be considered addressing the issue of independence by not only relieving that senior's dependency on family and friends for their grocery shopping, but by giving them some control over what they buy.

Finally, projects which clearly stated *how* they were addressing seniors independence would have been coded as addressing independence. As the question on addressing independence, as well as the questions on health and well-being and eliminating barriers, was an open-ended question on the data collection instrument and not a simple yes or no, it was important to know *how* a project was addressing this issue. In order to continue on to the next question/item, the analysts would have to explain how a project was addressing independence.

Instances where health and well-being played a role in addressing seniors independence would have been captured in one of two ways. The project would be coded as addressing health and well-being as well as independence or the health and well-being factor would have been noted in the explanation of how the project was addressing independence.

- ☐ ***Innovative Projects.*** Projects were considered to be innovative if they met any of the following criteria:
  - introduced a new approach;
  - addressed a new issue;
  - targeted different groups of seniors;
  - took place in a different milieu (e.g., rural/urban);
  - brought together different stakeholders; and
  - developed and synthesized new knowledge.

(b) Sub-Objectives

In addition to the long-term strategic directions, the Division also has five short-term goals and sub-goals, which are consistent with the Strategy's objectives and are achievable within the life of the current strategy. These goals are as follows:

- ☐ to increase and consolidate knowledge on aging and seniors' issues and to share this knowledge with other federal government departments, the provinces and stakeholders;
- ☐ to guide the development of programs, policies and strategies that are innovative, effective and address the needs of seniors and an aging society. This includes providing advice on programs and policies of stakeholders outside the federal government (e.g., professional associations);

- ❑ to promote a positive and realistic image of seniors to Canadian society through the Division's activities, communications and educational initiatives;
- ❑ to provide seniors with the information they need, as well as the opportunity, to make informed choices on issues that affect their health, well-being and independence; and
- ❑ to provide the National Advisory Council on Aging with the support it requires to fulfil its mandate.

(c) Program Elements

There are four program elements which comprise the Division of Aging and Seniors/Seniors Strategy: seniors community programs funding; the Seniors Independence Research Program; policy coordination and support to the Minister; and support to the National Advisory Council on Aging. Although each of these elements has its own set of objectives, the activities undertaken to meet the objectives all contribute to the achievement of the Division of Aging and Seniors and Seniors Strategy's goals. Each of these elements is described in detail below.

Seniors Community Programs Funding

It is within this program element that the contribution funding programs — New Horizons Program, Seniors Independence Program, Ventures in Independence and New Horizons: Partners in Aging — contained in the community funding profiles of both Strategies (1988, 1993) have been placed. As noted earlier, New Horizons, the Seniors Independence Program and Ventures in Independence were merged into the New Horizons: Partners in Aging program in April 1995. The delivery of the Seniors

Community Programs is the responsibility of the DAS Headquarters and the HPPBRO. Following is a discussion of each of these programs.

New Horizons Program

The New Horizons Program was first established in 1972 as a developmental program (National Health and Welfare, 1988). The awareness of Canada's aging population had resulted in increased concern over the rising costs of institutional care and the greater demand for services by and for retired persons. At the same time, it was also being recognized that there was a link between an active and meaningful lifestyle and the maintenance of health and well-being. The original thinking behind the Program was that it would open up opportunities for seniors feeling socially isolated and alone to help each other and their community by becoming involved in social activities. The original objective of the Program in July 1972 was (National Health and Welfare, 1988, p.1-2):

> *to enable retired persons to participate in projects which will engage them in meaningful activities and which at the same time will prove helpful to the community as to other people.*

Almost immediately, the Program started down the road of revision and modification. In December of the same year, the objective was modified to reflect the emphasis on funding ***groups*** of older Canadians (National Health and Welfare, 1988, p.1-2):

> *to enable groups of retired people to participate in activities which are designed to overcome patterns of social isolation of retired people in Canada and which will be beneficial to themselves, other Canadians and the community.*

This was not, however, the last time the New Horizons Program objective would be revised. It was modified again in 1975, this time to stress the selection, planning and operation of New Horizons projects by seniors (National Health and Welfare, 1988, p.1-3):

> *to provide meaningful opportunities for retired Canadians to plan, operate and participate in meaningful activities of their own choosing which will prove beneficial to themselves and the community.*

Based on this objective, a number of guiding principles were adopted for the management of the Program:

1. Although retired seniors would be responsible for choosing the activities and for their programming, younger people would still be able to participate.
2. As the seniors would be permanently retired, they would not receive salaries.
3. As it is the intention of the program to encourage group activities, only those groups with ten or more people would receive funding.
4. To encourage self-sufficiency, groups would receive funding for only a limited time.
5. All regions would have access to funding throughout the year.
6. Groups would be able to obtain advice and assistance from staff regarding the planning and organization of their activities, resources permitting.
7. Groups would be expected to report on the use rate of funds received.
8. Provinces would have the opportunity to comment on any projects being recommended for funding in their province.
9. Established agencies with salaried employees providing services to seniors would not be eligible for funding.

All applications for funding were evaluated against the eligibility criteria. The types of activities typically funded by the New Horizons program included: sports and fitness (e.g., lawn bowling in the 1970's and 1980's and tai chi in the 1990's); arts and crafts; performing arts and entertainment; history; media; education; service provision; organizational development and research. Fiscal restraints which led to budget cuts in 1987-88 coupled with pressure from the Senate Committee for more service-oriented projects resulted in the development of regional funding priorities, which were established each year, and the approval of more service-oriented projects (National Health and Welfare, 1988). New national priorities were added in 1991-92 which corresponded to and complemented priority areas identified by the Minister of State for Seniors.

Projects could receive funding for up to 18 months, although it could be extended for another 18 months. Generally, projects received funding for more than 18 months. As already indicated, the reasoning behind limited funding was to encourage projects to become self-sufficient. Projects that received funding were monitored and ongoing consultation with field staff was available to assist groups as needed. For evaluation purposes, data on the project were gathered and analyzed.

Outputs of the New Horizon Program included:

- the general public, senior citizens' organizations, and other government departments and agencies were provided with information regarding the Program;
- both activity-oriented and service-oriented projects were submitted in all regions across Canada;
- projects were funded;
- seniors were involved in the Program; and
- program reviews and reports were completed.

The primary reporting requirement of New Horizons was the completion of an Activity and Accounting Report. Final Reports were also produced as well as, in most recent years, Evaluation Reports.

On April 1, 1995, New Horizons was merged with the Seniors Independence Program and Ventures in Independence to comprise the New Horizons: Partners in Aging program. As noted in the previous section, this merger resulted in a program reorientation (e.g., objectives) and a change in operational modalities (e.g., priority setting process, proposal solicitation, review and approval process).

Since its inception in 1972, the New Horizons program has funded 38,935 projects at a total value of $256,562,770. The average level of funding of projects since the inception of the program is $6,598. During this time, the estimated number of individuals who participated in New Horizons projects within the first 22 years is 5,594,507. Table 1.2 breaks this information down by year. According to the file review conducted for this evaluation, the average duration of projects was 17.5 months.

Seniors Independence Program

The Seniors Independence Program (SIP) was initiated in April 1988 as part of the first five-year Seniors Initiative. This program was jointly managed by the Social Service Programs Branch and the Health Services and Promotion Branch. Its purpose, as outlined in the *Conceptual Framework* (National Health and Welfare, 1990, p.3), which was finalized in December 1990, was:

> *to enable seniors, acting on their own behalf and in collaboration with others, to increase their independence and quality of life.*

TABLE 1.2
New Horizons Program, Financial Table, Summary Report, 1972 to 1995

Fiscal Year	Allocation	Projects	Participants	Approved	Expenditures
1972-1973	$6,150,000	493	73,500	$3,387,631	$2,145,144
1973-1974	8,566,000	1,614	386,634	8,655,656	8,625,427
1974-1975	8,566,000	1,549	289,858	8,429,206	8,554,720
1975-1976	11,338,000	1,836	207,656	11,455,992	11,338,188
1976-1977	11,116,000	1,754	155,797	10,972,900	11,113,147
1977-1978	12,216,000	1,841	203,638	12,700,071	12,210,629
1978-1979	10,966,000	1,833	193,287	11,125,841	10,965,999
1979-1980	10,466,000	1,896	237,980	10,260,653	10,466,001
1980-1981	11,788,000	1,933	316,388	12,592,212	11,787,949
1981-1982	12,384,000	1,890	290,337	12,342,903	12,381,307
1982-1983	12,734,000	2,031	286,645	12,914,685	12,733,794
1983-1984	12,734,000	1,999	284,850	13,099,013	12,732,528
1984-1985	13,371,000	2,145	256,446	13,328,585	13,371,000
1985-1986	13,371,000	1,903	215,962	11,888,896	12,133,536
1986-1987	10,000,000	2,029	219,771	9,455,988	9,982,587
1987-1988	8,650,000	1,852	203,318	8,771,450	8,742,395
1988-1989	11,700,000	1,862	248,463	13,951,038	11,996,881
1989-1990	15,000,000	2,081	274,261	16,231,834	16,267,300
1990-1991	15,000,000	1,888	251,833	14,118,354	15,293,012
1991-1992	15,000,000	1,631	248,287	13,562,315	13,652,011
1992-1993	15,000,000	1,543	516,555	14,292,295	14,138,763
1993-1994	13,500,000	1,169	233,041	11,701,114	11,711,001
1994-1995	4,583,876	163	NA	3,751,079	4,219,451
Total	264,199,876	38,935	5,594,507	258,989,711	256,562,770

Source: Division of Aging and Seniors.

- "Allocation" is the amount of money allocated to the program in a given fiscal year; this amount reflects any upwards or downwards modification of the funding envelope in that given year;
- "Projects" is the number of (new) projects approved by the program in a given fiscal year;
- "Participants" is the estimated number of participants for all (new) projects approved by the program in a given fiscal year — as this information is a priori and so not completely accurate, it was no longer requested after 1993-94;
- "Approval" is the total contribution committed by the program to fund the (new) projects approved by the program in a given fiscal year; this amount will be expended during the given fiscal year and the two-or-three fiscal years following;
- "Expenditures" is the total contribution given by the program for all projects receiving funding in a given fiscal year; this amount funds (new) projects approved in that fiscal years as well as projects approved in previous years and still receiving funding.

Achieving independence involves having the right to make ones own choices and to be involved in the decision-making process. Quality of life also involves having the right to make choices and to act independently. It includes material, physical, mental and spiritual well-being which are affected, in part, by an individual's dignity, self-esteem and feeling of being valued by others.

The objectives of the program, as outlined in the *Guide for Applicants* (National Health and Welfare, no date on document), were as follow:

- ❑ to promote the involvement of seniors in the design and delivery of projects which affect their quality of life and independence;
- ❑ to encourage and support the self-care and mutual aid effort of seniors; and
- ❑ to promote the availability and accessibility of resources which support the health, education and social welfare of seniors.

There were six guiding principles that provided direction for this program (National Health and Welfare, 1990):

1. emphasize senior involvement in making decisions that will affect them;
2. give priority to seniors most in need;
3. stress the importance of community involvement through community development and community action;
4. define independence and quality of life using personal and social development terms;
5. contribute to the social change process; and
6. promote lifelong learning and development.

Projects funded under SIP could be either national or regional in scope. Projects were required, however, to involve seniors in the decision-making process. There were two main funding priorities:

1. Seniors most in need — senior women, seniors living in rural and remote areas and less advantaged seniors. SIP differed from New Horizons, however, in that it could provide funding to agencies or organizations that work for seniors and not just groups of seniors.

2. Projects using a community development approach which resulted in seniors being able to identify their own needs.

The main activities undertaken by SIP included:

- ☐ Funding time limited projects. Like the New Horizons Program, funding from SIP, although consistently greater in average funding and duration than New Horizons projects, was only for three years.

- ☐ Consulting and collaborating with government departments/agencies and NGOs to coordinate plans, activities and programs.

- ☐ Providing information, advice and expertise.

- ☐ Collecting, analyzing and distributing information about SIP activities and project results.

- ☐ Conducting special activities.

According to the *Conceptual Framework* (National Health and Welfare, 1990), there were six outcomes which the program strove to achieve:

- ☐ seniors' involvement and empowerment;
- ☐ focus on seniors most in need;
- ☐ recognition of seniors by society;
- ☐ partnerships and collaboration;
- ☐ knowledge and skills development; and
- ☐ attitudinal change in society about seniors.

Initially, at the end of each SIP project, project sponsors were required to submit a final report. In later years they were required to submit a SIP Impact Questionnaire and an evaluation report.

Table 1.3 presents information on the number of projects, participants and the amount of funding that was both allocated and expended by year. In total, $78,234,845 was expended on 679 projects. The average duration of SIP projects was 23.4 months and the average level of funding was $130,955.

TABLE 1.3
Seniors Independence Program
Financial Table, Summary Report
1988 to 1995

Fiscal Year	Allocation	Projects	Approved	Expenditures
1988-1989	$16,000,000	78	$11,724,998	$2,574,999
1989-1990	20,000,000	251	33,041,929	13,542,387
1990-1991	16,707,600	77	8,610,811	16,668,985
1991-1992	15,383,000	38	6,004,089	14,856,913
1992-1993	13,000,000	67	6,004,727	12,762,109
1993-1994	12,750,000	123	14,445,786	8,270,817
1994-1995	10,124,146	45	5,811,255	9,558,635
Total	103,964,746	679	85,643,595	78,234,845

Source: Division of Aging and Seniors.

Notes: See notes to Table 1.2

Ventures in Independence

Ventures in Independence was introduced in April 1993 when the Seniors Strategy was renewed for a second five-year period (Health Canada, 1995d, p.5). The objective of this program was:

> *to involve seniors in new partnerships with business, labour and other levels of government to address issues of aging and independence.*

Outcomes of Ventures projects included:

- ☐ partnerships with the private and public sectors;
- ☐ seniors involvement;
- ☐ projects funded; and
- ☐ reports and evaluations completed.

As with New Horizons and SIP, Ventures in Independence became a part of New Horizons: Partners in Aging in 1995.

Upon completion, Ventures projects were to submit an Impact Questionnaire and Final Report. Evaluation Reports have also been provided.

A total of 29 projects were funded under Ventures in Independence. While $3,591,978 was allocated to this program, only $2,158,307 was expended. Information on projects and finances by year is provided in Table 1.4. The average duration of Ventures in Independence projects since the programs inception was 23.2 months and the average level of funding is $130,832.

TABLE 1.4
Ventures in Independence
Financial Table, Summary Report
1993 to 1995

Fiscal Year	Allocation	Projects	Approved	Expenditures
1993-1994	$2,000,000	16	$2,318,771	$933,527
1994-1995	1,591,978	13	1,634,999	1,224,780
Total	3,591,978	29	3,953,770	2,158,307

Source: Division of Aging and Seniors.

Notes: See notes to Table 1.2.

New Horizons: Partners in Aging

On April 1, 1995, New Horizons, the Seniors Independence Program and Ventures in Independence were amalgamated to form New Horizons: Partners in Aging (NH:PA). The amalgamation of these programs resulted in a reorientation of their focus towards funding programs aimed at seniors who are most "at risk", although it is important to keep in mind that the SIP already focused on seniors "most in need".

The purpose of this program, as outlined in the *Conceptual Framework* (Health Canada, 1995a, p.3), is:

> *to foster the involvement of seniors and their partners in action to improve the health, well-being and independence of seniors in situations of risk or prevent situations which put seniors at risk.*

This purpose can be broken down into three main objectives:

- to meet the needs of seniors in situations of risk or to prevent situations which put seniors at risk (this is the primary objective of the program which all projects must meet);
- to find innovative processes and solutions and evaluate and share project results;
- to build partnerships between seniors and others interested in working on issues that face seniors and an aging society.

The principles upon which this program is based are as follows:

- ***Seniors as Contributors.*** Seniors' experience and understanding of the issues which face their peers, particularly those in situations of risk, make them significant contributors to society. Their assistance in meeting program objectives is invaluable.
- ***Reducing Inequity.*** By addressing the needs of seniors living in situations of risk or preventing these situations from occurring, this program strives to reduce the inequity of seniors whose health, well-being and independence are being threatened by such situations.
- ***Target Group Involvement.*** As it is those seniors living at risk that are the most capable of defining their needs and determining the responses that will best address those needs, it is important to have them actively involved in the program.
- ***Innovation, Learning and Sharing.*** New innovative approaches are needed to address the challenges created by Canada's aging population. In addition to developing innovative approaches, it is also important to share the lessons learned from the various projects initiated under the program.
- ***Working Together.*** A healthy aging society is not a goal that can be achieved by one group alone. This program realizes that in order to maximize impact on the health, well-being and independence of seniors living in situations at risk, it will be necessary for partnerships between seniors, government, non-government organizations, business and labour to develop.

Funding priorities for NH:PA are set nationally and regionally in consultation with seniors, community groups and organizations and government representatives (Health Canada, no date on document). This process provides stakeholders with the opportunity to refine the Program's definition of situations of risk (Health Canada, 1995g). By establishing priorities, the program can ensure that funding will be targeted towards those areas where it will have the greatest impact. Although the priorities vary across provinces/territories, three common issues that have been identified are: seniors who are physically or socially isolated; informal caregiving and the needs of caregivers; and the abuse and neglect of seniors.

The primary activities of this program, as outlined in the *Conceptual Framework* (Health Canada, 1995a), include to:

- ☐ fund community-based and national projects which target seniors at risk;
- ☐ involve stakeholders in the development of program strategies, including the setting of national and regional priorities;
- ☐ collect, evaluate, synthesize, compile and disseminate all information, products and models which result from program activities;
- ☐ build partnerships between seniors and others interested in working on seniors' issues; and
- ☐ provide advice and expertise on issues related to aging.

The outcomes which NH:PA strives to achieve, but to which it is not limited are as follows:

- ☐ contribute to enhancing the health, well-being and independence of seniors at risk;
- ☐ increase the opportunities for the participation and involvement of seniors at risk;

- ☐ contribute to the acquisition of knowledge and skills by seniors at risk which will enable them to speak on their own behalf;
- ☐ increase the number of effective community resources, programs and strategies which address the needs of at risk seniors;
- ☐ increase public awareness of seniors' issues;
- ☐ develop innovative solutions for responding to the needs of seniors at risk;
- ☐ increase knowledge and understanding of seniors' issues and strategies to effectively address them;
- ☐ influence health and social policies, program design and service delivery which are based on the knowledge gained from program activities;
- ☐ develop new and strengthened partnerships and networks to address the issues of at risk seniors;
- ☐ increase the contributions and participation of stakeholders in the development of program policies and strategies;
- ☐ increase the resources by partners to meeting the needs of at risk seniors; and
- ☐ increase the recognition of seniors as contributors who occupy valued roles in society.

Reporting requirements for NH:PA include the submission of a Final Report and an evaluation.

Financial information as well as the number of projects that have been funded under New Horizons: Partners in Aging are presented in Table 1.5. As the table indicates, in 1995-96, $10,885,905 was expended on 143 projects. The average level of funding for NH:PA projects approved in 1995-96 is $47,854. The average duration of these projects is 14 months. Of note is that, while the *Terms and Conditions of the New Horizons Program Fund* (Health Canada, 1994d) state that the maximum period of support will normally be three years, the *Guide for Applicants* (Health Canada, no date on document) indicates that the period of funding will not normally exceed 24 months.

TABLE 1.5
New Horizons: Partners in Aging Financial Table, Summary Report 1995 to 1996

Fiscal Year	Allocation	# Projects	Approved	Expenditures
1995-1996	$15,237,000	143	$6,567,823	$10,885,905
Total	$15,237,000	143	$6,567,823	$10,885,905

Source: Division of Aging and Seniors.

Notes: See notes to Table 1.2

After New Horizons, SIP and Ventures were merged into NH:PA, the three programs ceased to exist while some of their projects were still ongoing. Outstanding commitments, therefore, are coming from the NH:PA allocation. That is:

- ❑ $1,474,824 were paid to NH projects in 1995-96, $872,170 are committed to NH projects in 1996-97 and $7,000 are committed to NH projects in 1997-98, for a total of $258,909,765 spent/committed for NH projects approved from 1972-73 to 1994-95;
- ❑ $6,546,056 were paid to SIP projects in 1995-96, $4,057,299 are committed to SIP projects in 1996-97 and $81,019 are committed to SIP projects in 1997-98, for a total of $88,919,149 spent/committed for SIP projects approved from 1988-89 to 1994-95;
- ❑ $821,897 were paid to Ventures projects in 1995-96, $706,756 are committed to Ventures projects in 1996-97 and $107,162 are committed to Ventures projects in 1997-98, for a total of $3,794,122 spent/committed for Ventures projects approved in 1993-94 and 1994-95;

- conversely, NH:PA projects only claimed $2,007,002 from the NH:PA allocation for 1995-96, and are expected to claim $11,332,124 of the 1996-97 allocation.

Seniors Independence Research Program

The Seniors Independence Research Program (SIRP) was first introduced as part of the initial five-year Seniors Initiative which was announced in February 1988 (Health Canada, 1996b). While the coordination of this program is provided by the Division of Aging and Seniors, the administration of its contributions are handled by the National Health Research and Development Program (NHRDP). The purpose of the Seniors Independence Research Program is (Health Canada, 1996b, p.1):

> *to strengthen national research with a balanced emphasis on social, economic and health determinants of independence for both today's and tomorrow's seniors.*

An underlying theme of this program is to encourage and promote partnerships not only within the research community, but also between the research community and groups such as seniors, business, non-governmental organizations, voluntary organizations, the health and social services community, and government policy advisors and decision-makers.

SIRP's current priorities include (Health Canada, 1995h):

- the encouragement of multidisciplinary research leading to relevant and practical information;
- the focusing of research on the primary social, economic and health factors affecting seniors' independence;

- the continued study of dementias such as Alzheimer's disease and the development of research on osteoporosis;
- the analysis of data from large surveys;
- the dissemination of research findings from the first and second initiatives and their implications;
- the monitoring of seniors' health problems and the development of strategies that will reduce their impact; and
- the strengthening of Canada's capacity in regards to social and health research.

SIRP activities are both numerous and varied (Health Canada, 1996b). Although the program does provide funding for research activities, it is not strictly a funding program. As the following list of activities illustrates, it is also involved in monitoring activities (e.g., surveillance of diseases), policy and dissemination activities:

- special competitions through a Program of Applied Research on health, social and economic issues related to seniors' independence on four main themes;
- special competitions to foster and support research into the health, social and economic aspects of aging including personnel support to agencies to enable them to conduct research on community-based health and social issues related to the independence of seniors;
- follow-up studies related to the first initiative such as the Canadian Study of Health and Aging which is a collaborative multi-centre study involving 18 centres from all provinces; sponsored by NHRDP and, for the first phase, coordinated by the University of Ottawa and the Health Canada Laboratory Centre for Disease Control (LCDC), and the second phase was done by the University of Ottawa and DAS/S;
- surveillance, risk assessment and disease control of diseases affecting seniors;
- workshops, conferences on social, economic and health determinants of independence for both today's and tomorrow's seniors; and

❑ implementing effective strategies for the dissemination of the research findings.

There are a number of groups involved in the activities of SIRP. The SIRP Advisory Committee, which includes researchers, seniors' representatives and NGOs, disseminates SIRP research findings and provides guidance on the orientation of priorities for SIRP. The Extramural Research Division also collaborates actively with this Advisory Committee and is directly involved in the management of SIRP. Other partners in SIRP activities include universities, centres on aging and provincial/territorial policy makers.

The SIRP components within the Division of Aging and Seniors are responsible for coordinating the program and for providing the SIRP Advisory Committee with support for its operations. In addition to these responsibilities, the SIRP components are responsible for the surveillance of diseases and for risk assessment activities.

Information on the number of projects undertaken between 1991 and 1996 is presented in Chapter Two. Based on the file review of SIRP funded projects, projects last 19 months on average. The amount of money committed to the projects reviewed ranged from $3,079 to $4,996,674, with the average amount received being $405,994. Financial information is presented in Table 1.6. As the table indicates, there has been a total of $25,898,974 in expenditures between 1988-89 and 1995-96.

TABLE 1.6
NHRDP's SIRP Budget and Expenditures

Budget	1988-89	1989-90	1990-91	1991-92	1992-93	1993-94	1994-95	1995-96
SIRP/NHRDP Budget	$1,250,000	$3,450,000	$3,750,000	$3,250,000	$2,250,000	$1,018,000	$2,050,000	$2,545,000
Other Funding Sources								
NWG*	-	-	-	-	-	620,000	1,600,000	1,800,000
CDS**	-	-	-	-	-	-	89,000	399,200
Total SIRP Budget	1,250,000	3,450,000	3,750,000	3,250,000	2,250,000	1,638,000	3,739,000	4,744,200
Total Expenditures	1,227,474	1,760,988	4,506,194***	4,414,260***	2,136,214	1,725,859***	3,676,040	6,451,945***

Source: National Health Research and Development Program.

* Amounts transferred from National Welfare Grants (NWG) when they moved to Human Resources Development Canada.

** Amounts contributed by Canada's Drug Strategy (CDS) (II) towards joint SIRP/CDS special competitions (Programs of Applied Research [PARs] (Tamblyn) and Community Researcher Awards [CRAs] (Tjam, Embree, Montbriand, Spencer, McGowan)).

*** Over-expenditures were/are picked up by Departmental lapsing funds.

Policy Coordination and Support to the Minister

Policy coordination and support to the Minister was first introduced under the initial Seniors Strategy in 1988, through the creation of the Seniors Secretariat (Health Canada, 1995c). Prior to this (from 1980 to the late 1980s), an Office on Aging existed within Health Canada, which served as a focal point for all policy matters related to aging. Additionally, support to the Minister of Health and Welfare was provided by the Seniors Strategy through funds to the Health Economics and Systems Analysis Division (PCB). These functions were maintained when the Seniors Strategy was renewed in 1993. This program element is responsible (Health Canada, 1995d, p.11):

> *for providing expertise and leadership on seniors and aging issues, and coordinating Health Canada, other federal government and federal/provincial/territorial initiatives on seniors and aging issues, as well as providing education and information to the public.*

In the carrying out of these responsibilities, the policy coordination and support element:

- provides advice on the needs, priorities and programs related to aging and seniors to the Minister of Health and other federal departments;
- provides support to the Minister of Health and the Federal/Provincial/Territorial Ministers Responsible for Seniors;
- coordinates and manages Health Canada activities aimed at seniors including the Seniors Strategy;
- coordinates federal government activities aimed at seniors;
- develops and coordinates federal policies on aging;

- ❑ coordinates interdepartmental and federal/provincial/territorial shared initiatives; and
- ❑ provides education and information to the public through public education campaigns, the provision of information services and communications.

One of the activities that falls under the mandate of this program is the Interdepartmental Committee on Seniors Issues (IDCSI). This Committee was created in 1994 at the instigation of the then Seniors Directorate and Senior Management of the then Health Services and Programs Branch. Membership on this committee is comprised of Assistant Deputy Ministers/delegates from the federal departments and agencies with an interest in seniors' issues (e.g., Transport Canada, Canada Mortgage and Housing Corporation, Department of Indian and Northern Affairs, Industry Canada, Veterans Affairs Canada). This committee meets quarterly and its activities include to:

- ❑ improve the exchange of information on departmental research activities and policies concerning seniors and an aging population;
- ❑ identify emerging priorities and initiatives;
- ❑ identify and increase opportunities for bilateral or multilateral collaboration;
- ❑ share results of innovative initiatives; and
- ❑ provide input for Federal/Provincial/Territorial meetings of Ministers Responsible for Seniors.

National Advisory Council on Aging

The National Advisory Council on Aging (NACA) was initiated in 1980 in response to a recognized need by the Minister of Health and Welfare for independent advice and research on aging and seniors' issues (Health Canada, 1995d). It is an independent advisory body that has an arm's length relationship with Health Canada. Research and Secretariat support is provided to the Council by the DAS. NACA money committed under the DAS/S is for support to NACA by DAS. It is important to note at this point that NACA is not being evaluated as part of this study. NACA's activities will only be examined to determine whether NACA has contributed to meeting DAS/S's objectives.

This Council is comprised of up to 18 members from all parts of Canada and all walks of life[6]. They are appointed by Order-in-Council for two- or three-year terms which can only be renewed once. The primary responsibility of NACA is:

> to assist and advise the Minister of Health on all matters related to the aging of the Canadian population and the quality of life of seniors.

It carries out this responsibility by providing recommendations on current and upcoming priorities. It also undertakes activities that reinforce its advisory capacity. NACA activities include:

- ☐ reviewing the needs and problems of seniors and recommending remedial action by consulting seniors and experts, monitoring policy developments in Canada and abroad, conducting documentary research and qualitative and quantitative analysis and by selecting the best policy and program alternatives;
- ☐ maintaining contact with national, provincial and local associations, institutions and groups involved in aging or representing seniors;
- ☐ distributing information through a mailing list of interested individuals and organizations, appearing before parliamentary committees, exhibiting material at conferences and answering individual requests;

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6. Unless otherwise specified, information on NACA comes from various NACA publications and pamphlets.

- ☐ publishing reports, such as *NACA Position Papers, Expression, Info-Age, Vignettes, Writings in Gerontology, Forum Collection Papers, Challenge Papers*; and
- ☐ stimulating public discussion on aging by organizing panel discussions and workshops, promoting special events and initiatives through press releases, submitting articles to newspapers and professional journals and by cooperating with the media to create a greater national awareness of aging issues.

NACA's activities have resulted in a number of outcomes. Following are some of their activities' outcomes and end products since 1993 (The National Advisory Council on Aging, 1996):

- ☐ policy recommendations on women's life-course, long-term care and medication use, community services in health care for seniors, priority setting in health care, technology in health care, retirement income and pensions, and the Canada Pension Plan;
- ☐ effective coverage of seniors' issues through NACA's continued contact with seniors and seniors-related organizations as well as its close collaboration with informed contacts at the national, provincial and local levels;
- ☐ raised the understanding and debate on questions such as atrial fibrillation, Aboriginal seniors' issues, family relationships, and inappropriate medication use; and
- ☐ information has been disseminated through published documents such as *NACA Position Papers, NACA Briefs, Writings in Gerontology, Forum Collection, Aging Vignettes, Expression,* and *Info-Age.*

1.3 Objectives of the Evaluation

The methodological approach used in the evaluation is based on multiple lines of evidence which, together, address each of the evaluation issues. Evidence has been collected from several sources and through the use of the following methods: a review of the literature and available data bases; a review of projects files; key informant interviews; survey of intended beneficiaries; survey of the general public clients; the sponsorship of three items on a national survey; and expert consultations. These methods are further explained in Chapter Two.

The evaluation objectives were organized into three broad issue areas which directed the development of the methodology and the thrust of the overall evaluation. These are: 1) the continued relevance of the DAS/S in view of the current needs of seniors; 2) the accomplishments from having funded the DAS/S over the past five years, namely on the health, well-being and independence of seniors in general and more particularly of seniors at risk; and 3) possible alternatives to the DAS/S.

In the context of the Auditor General's 1995 Report, in which he states that the Office will be following up on the evaluation after it is completed, focusing on the extent to which it has provided "... evidence necessary for strategic decisions about continuing, discontinuing or revamping the Seniors Strategy", the need for credible and rigorous evaluation data becomes all the more critical.

Program Relevance

Some of the most challenging and interesting issues lie in the area of program relevance and rationale. Key questions include: Is there a documented need and demand for the program? Does the program continue to be relevant?

These questions were framed within the broader context of activities in the area of seniors, particularly those of the provincial/territorial governments, as well as those sponsored and administered by local governments. In this way, an activity or program's relevance was not measured solely in terms of its perceived effects on clients, but also the extent to which it duplicates or hampers delivery of other similar programs.

Program Accomplishments

Questions of program accomplishment encompass what Treasury Board has labelled "objectives achievement" issues. These issues pertain to intended impacts and effects for which the program is held accountable. The core question here is: To what extent has the program achieved its stated objectives? This is arguably the most important issue — did the program accomplish the things it was supposed to? The causal attribution of program results to program activities is one of the most demanding of evaluation problems.

With respect to the achievement of DAS/S objectives, it is important to attempt to determine what worked, what did not and why, so that the current program can be justified (if it is in fact working well) and future programs of this type can be improved.

Alternatives

Evaluation questions related to the broad issue of alternatives are very important in light of the current era of fiscal restraint. In the examination of questions surrounding possible alternatives to the DAS/S or its component activities, the evaluation must attempt to provide credible responses which will allow program designers and administrators to maintain those programs and activities which provide the greatest value for money, particularly in areas where the federal government is the major provider of seniors programs. At the same time, the evaluation must provide credible evidence which can be used to determine which programs can be reduced, amalgamated or eliminated.

Evaluation Questions

The evaluation questions contained in the Terms of Reference for this study are presented in Table 1.7. These are the priority evaluation questions identified in the evaluation framework (out of a total of 23 questions) and answers to these provide relevant information for addressing, at least to some degree, the other questions identified in the evaluation framework.

1.4 Purpose and Organization of the Report

As already noted, the purpose of this document is to integrate the findings which emerged from the evaluation field work (i.e., interviews and surveys) with the findings of the literature review, the extant data base review and the file review. In Chapter Two, we briefly describe the methodological approach utilized in each of these components of the evaluation. The integrated analyses of the findings are organized and presented by the three main study issues outlined above (i.e., program relevance, accomplishments, and alternatives) with each broad issue area constituting its own chapter. The report is organized according to key evaluation questions within the study issues. The focus for reporting has been on attempting to provide concise answers to the key evaluation questions. Detailed findings from the separate data collection exercises have been presented in background reports[7] and hence, are not repeated in this document. In the final chapter, the overall conclusions which can be drawn from the integrated analysis are presented.

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[7] Ekos Research Associates, *Revised First Interim Report*, submitted to the Evaluation Group — Health Canada, September 4, 1996; Ekos Research Associates, *Revised Second Interim Report*, submitted to the Evaluation Group — Health Canada, October 15, 1996.

TABLE 1.7
Evaluation Questions as Approved in the Terms of Reference for the Evaluation of the Division of Aging and Seniors/Seniors Strategy

	Evaluation Questions
1.	Is there still a need for a program dedicated to enhancing the health, independence and well-being of seniors? If so, which groups of seniors and which priority needs should such a program address and why (i.e., on what evidence are these priorities based)?
2.	Is there a continuing role for the federal government and Health Canada to intervene in the promotion of the health, independence and well-being of seniors? What is the mandate under which the Department acts in this area?
3.	Has the DAS/S met its short term goals, without significant unwanted outcomes? To what extent does the work accomplished to date contribute to the DAS/S' long-term strategic directions?
4.	To what extent has the DAS/S addressed priority needs of seniors and an aging society?
5.	To what extent has the DAS/S had a direct impact on the health, independence and well-being of seniors, including those seniors living in situations of risk?
6.	To what extent has the DAS/S induced its partners, including seniors, to contribute resources, either financial or in-kind, to collaborative/partnership activities?
7.	To what extent has the DAS/S increased knowledge on, and the number of useful available resources to and for seniors and an aging society?
8.	To what extent has seniors community program funding: enhanced seniors' health, independence and well-being; addressed the priority needs of seniors in situations of risk or in danger of being at risk; supported the development of innovative programming; and increased the collaboration/partnership opportunities among seniors, and between seniors and other sectors of society on issues pertaining to seniors and aging issues?
9.	What have been the effects of the seniors community funded projects, beyond the direct benefits generated, in terms of continuing/new projects, activities and collaboration/partnership after the initial funding ceased? What were the characteristics of those projects that had on-going benefits?
10.	Which DAS/S activities and projects were most cost-effective? What characterized the most effective projects and activities from the less effective ones?
11.	Do the various activities of the DAS/S, other departmental activities, and activities outside the Department complement and supplement one another or is there overlap and duplication?
12.	What mechanisms or approaches would be most cost-effective and appropriate for the federal government and Health Canada to pursue in light of governmental and non-governmental priorities and concerns in the area of seniors and aging and in light of diminished resources?
13.	What would be the most cost-effective and appropriate structures for supporting these mechanisms or approaches?

CHAPTER

2

METHODOLOGY

In this chapter we provide a description of each of the methodologies utilized in the evaluation of the Health Canada Division of Aging and Seniors/Seniors Strategy.

2.1 Literature Review

The objectives of the literature review, presented in a separate technical report[8], were as follow:

- ❑ to provide a foundation for the analysis, including current thinking on major trends and issues and the identification of seniors' needs;
- ❑ to benefit from any previous evaluation work on these or similar programs, either here in Canada or in other countries;
- ❑ to refine the study team's understanding of the key issues and facilitate the formulation of questions to be used in the interviews and the surveys; and

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8. Ekos Research Associates, *Revised First Interim Report*, submitted to the Evaluation Group — Health Canada, September 4, 1996.

- ❑ to allow the evaluation to benefit from any new findings in fields affecting seniors and an aging population, including a focus on possible alternatives to the DAS/S.

In order to limit the focus of the review to the needs of the evaluation and the evaluation questions, the literature review focused on four key areas:

- ❑ the current situation of seniors in Canada, including the incidence or level of risk to seniors in Canada;
- ❑ comparison of seniors to other "at risk" populations;
- ❑ federal and provincial/territorial responsibilities for addressing seniors needs; and
- ❑ current strategies of provincial/territorial governments and selected western industrialized countries (i.e. United States, United Kingdom, Sweden, Denmark, Norway, Australia, France, Germany).

Literature was obtained from a number of sources. Background literature on the Division of Aging and Seniors/Seniors Strategy and its program elements, as well as other relevant materials, such as information on international strategies, was provided by the DAS. There were also a number of documents cited in the Request for Proposal which were reviewed. Finally, the holdings of the Health Canada and other libraries were examined for relevant materials and bibliographic and citation indices were utilized to locate academic works. As NACA is not being evaluated per se and as it is an independent advisory body with credible sources, NACA publications were used as sources for the literature review. While the majority of literature reviewed dated back no further than 1991, in some instances statistics dating as far back as 1981 were examined.

2.2 Baseline Data Review

The DAS/S has contributed to the planning and the conduct of three surveys:

- ☐ the General Social Survey[9];
- ☐ Ageing and Independence[10]; and
- ☐ the Elder Monitor[11].

The information from these surveys was helpful for establishing baseline data to contribute to the measurement of changes over time for subsequent evaluation efforts. The data were also reviewed for their use as a secondary data source to respond to evaluation questions in the present evaluation study.

Prior to reviewing the data from the surveys, survey items were compared to the performance indicators developed in the evaluation framework in order to determine what data would be pertinent to the evaluation.

2.3 File Review

The purpose of the project file review was to provide qualitative and quantitative data on the activities and outputs of the projects within each program element. The original intention of this review was to examine project evaluations which would have provided information on project success and cost-effectiveness as well as provide insight into process issues. Unfortunately, evaluations do not exist for the vast majority of projects and so other information was taken from individual project files.

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[9] Statistics Canada, *General Social Survey*: GSS Analysis Series, 11-612E No.1 (1985) — Health and Social Support; GSS Analysis Series, 11-612E No. 4 (1991) — Where does time go; GSS Analysis Series, 11-612E No.8 (1994) — Health status of Canadians; GSS Analysis Series, 11-612E No. 9 (1994) — Family and Friends.

[10] Statistics Canada, *Survey on Ageing and Independence*, 1993a.

[11] The annual *Elder Monitor* survey, conducted by Synergistics Consulting, Toronto, 1996.

Projects were randomly sampled from all four of the DAS/S' program elements. The breakdown of the sampling and files reviewed are presented in Table 2.1. While some of the project elements can be traced back as far as the early 1970s, it was decided to only sample those projects that have been undertaken in the past five years to coincide with the timeframe under consideration for the overall evaluation. As Table 2.1 indicates, not all Seniors Community Programs Funding files sampled were received. Regional staff were unable to locate one of the New Horizons project files and two Ventures project files and two SIP project files were never received. Three outstanding NH:PA project files and one SIP project file were received too late to be incorporated into the file review for these programs. All project files were reviewed in our Ottawa office.

A stratified random sampling strategy was utilized to ensure a sufficient mass within each cell as well as to place the bulk of the projects for the file review within the New Horizons category as this is where they are most numerous in the population. This breakdown allowed us to speak in general terms about each of the individual types of projects. Community funded and SIRP projects were also sampled to provide a representative sample of all the provinces/territories as well as whether they were ongoing or completed and their funding level (e.g., whether they fell in the top half or bottom half of funding amounts received). While funding levels were divided in half for SIRP and other community funded projects, funding levels were divided into thirds for New Horizons and New Horizons: Partners in Aging.

TABLE 2.1
Distribution of Projects for File Review

	1991-92	1992-93	1993-94	1994-95	1995-96	Ongoing ('91-95)	Overall ('91-96)
Seniors Community Programs Funding							
New Horizons: Partners in Aging (n=143)							
Population					143	-	143
Sampled	-	-	-	-	45	-	45
Reviewed	-	-	-	-	42	-	42
New Horizons (n=4,506)							
Population	1631	1543	1169	163	-	-	4506
Sampled	20	20	45	45	-	-	130
Reviewed	20	19	45	45	-	-	129
Seniors Independence Program (n=273)							
Population	38	67	123	45	-	-	273
Sampled	10	10	30	20	-	-	70
Reviewed	10	9	30	18	-	-	67
Ventures in Independence Program (n=29)							
Population	-	-	16	13	-	-	29
Sampled	-	-	10	10	-	-	20
Reviewed	-	-	10	8	-	-	18
Seniors Independence Research Program (n=110)							
Population	-	-	-	-	-	-	110
Sampled	-	-	-	-	-	-	30
Reviewed	-	-	-	-	-	-	30
National Advisory Council on Aging (n=83)							
Population	16	10	13	10	16	18	83
Sampled	3	5	5	7	3	2	25
Reviewed	3	5	5	7	3	2	25
Internal Projects (n=211)							
Population	34	33	33	38	73	-	211
Sampled	5	5	6	6	8	-	30
Reviewed	5	5	6	6	8	-	30
TOTAL							
Population	1719	1653	1354	269	232	18	5355
Sampled	38	40	96	88	56	2	350
Reviewed	38	38	96	84	53	2	341

Collection of Data

In order to facilitate the collection of data, a data collection form was developed (see Appendix C). The design of the data collection form was based on a careful review of all the evaluation issues as well as the indicators which were proposed to address each of the evaluation issues. This clear and precise specification of the types of information to be collected was critical to ensure that the appropriate data were obtained and that similar information, to the extent possible, was recorded across all program elements. In order to make the analysis of the information more efficient, the guide was put into a Computer Assisted Telephone Interviewer (CATI) program, which meant that a data base was automatically created as the information was entered.

Given the diversity of programs included in the DAS/S and the differences in length of existence, the type of information collected and retained in the project files as well as the type of reporting and documentation required varied across and within programs. For the Seniors Community Programs Funding, once the data collection instrument was in place, a review of a sample of Seniors Community Programs Funding project files was undertaken to determine the sort of documents retained in the files and to select which of these should be requested from the Regional Offices for each of the sampled projects. It is important to note that it was known that not all documents requested would necessarily be available for all projects. Following this preliminary review of files, the following documents from community funded programs were requested (and obtained) from the regional offices as well as the national office (i.e., DAS):

☐ Funding Approval Form;
☐ Applications (if available);
☐ Activity and Accounting Reports (for New Horizons projects);
☐ Impact Questionnaires (for SIP and Ventures projects);

- ❑ Interim Reports (when final reports were not available, such as when the project was not yet completed);
- ❑ Quarterly Narratives (when final reports were not available, such as when the project was not yet completed);
- ❑ Final Reports (for completed projects for which this was a requirement, i.e., NH:PA, SIP); and
- ❑ Evaluation Reports (for completed projects for which this was a requirement, i.e., NH:PA, SIP).

In addition to these documents, information was also requested from the Contribution Information System (CIS) — a computer database maintained by the DAS. The information utilized included:

- ❑ project number;
- ❑ duration of the project; and
- ❑ total amount of dollars committed.

Of note is that, prior to 1993, there were several different information systems being used. Therefore, although the CIS contains complete information on the Seniors Independence Program from 1988 as well as on Ventures and NH:PA, information on projects funded through New Horizons are incomplete prior to 1993. In fact, the requested information was not available from the CIS for 29 of the New Horizons projects sampled in the 1991-92 and 1992-93 time periods. For these 29 projects, this information was obtained from the original application form.

The SIRP project files were obtained from the NHRDP and the NACA and Internal project files were obtained from the Division's head office. Both the SIRP staff and the Division head office were informed of the type of information required for the file review to aid them in gathering the files together.

The file review contains detailed information on each project including target group, clients, issues addressed, activities, partnerships and outputs. As this level of information is not replicated in the present document, the interested reader is directed to the technical reports[12,13]. It should also be noted that a few weaknesses in the overall level and/or quality of the information available in the files posed challenges to the collection of the information. For example, due to differing program requirements as well as the fact that some projects reviewed were ongoing and others had just completed, project evaluations were not available for a substantial number of the projects reviewed. This made it difficult to report on impacts and effects, and strengths and weaknesses. Limited information on partnerships and volunteers also proved to be a challenge to the accurate reporting of project findings.

2.4 Key Informant Interviews

A total of 119 key informant interviews were conducted. Approximately 25 per cent (or n=30) of these were conducted face-to-face while the remaining interviews were done by telephone. In-person interviews were conducted with respondents in the National Capital Region wherever possible. These face-to-face interviews were an average of one to one and a half hours in duration.

The length of telephone interviews varied greatly by type of interviewee. For example, interviews with regional directors took, on average, about one and a quarter hours whereas interviews with non-funded applicants rarely lasted more than 30 minutes. Taking all interviewee types together, the average interview length was approximately 45 minutes.

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[12] Ekos Research Associates, *Revised First Interim Report*, submitted to the Evaluation Group — Health Canada, September 4, 1996; Ekos Research Associates, *Revised Second Interim Report*, submitted to the Evaluation Group — Health Canada, October 15, 1996.

[13] Findings are summarized where appropriate in Chapters 3 to 5.

Key informant interviews can be a very useful qualitative tool. When the total number of interviews numbers over a hundred, it is tempting to want to deal with the results in a quantitative way; that is, to provide the absolute number of individuals or percentage who feel a certain way. This, however, would be misleading. One must recall that of the 100 plus interviews that were conducted, the findings represent different perspectives and these can often be broken down further by province/territory, project, and so on. Thus, the findings presented here have not been interpreted quantitatively. Instead, the results are intended to give an overall impression of the views of each respondent type and, in some cases, provide suggestions for improvement or specific examples.

The interview guides were prepared in close consultation with the client and DAS personnel (please see Appendix D). All interviewees were sent a copy of the interview guide by facsimile in advance of their appointment.

Table 2.2 presents a breakdown of the 119 completed interviews by type of key informant. Interview candidates were carefully selected in close consultation with the client and DAS personnel. In some instances, the initial candidate identified for consultation was not available. In most cases they were able to provide us with the name of an alternate individual whom they felt was equally qualified to answer the questions. Anticipating that some individuals and organizations (for stakeholder interviews) might be unable or unwilling to participate, alternate names (or organizations in the case of stakeholder interviews; alternate projects in the case of funded and non-funded applicant interviews) were provided by DAS personnel. All interviewees were assured of confidentiality.

TABLE 2.2
Overview of Completed Key Informant Interviews

Type of Interviewee	Number of Interviews
Central Agencies	2
Health Canada Senior Managers and Staff	28
Interdepartmental Committee on Seniors Issues	7
NACA Members	5
Provincial/Territorial Governments[14]	16
Stakeholders	34
Funding Recipients	17
Non-Funded Applicants	10
Total	119

Of the eight interview respondent types, respondent groups can broken down into sub-groups. This information is provided in Appendix E.

2.5 Surveys

Two surveys were conducted as part of the evaluation; these were a survey of intended beneficiaries of community funded projects and a survey of general public clients.

The *survey of intended beneficiaries* was geared towards gathering information on the impact of DAS/S on the lives of the intended project beneficiaries as well as views about the top issues facing seniors and their opinions regarding the level of government support for different areas. For the purpose of this study, after consultation with the client and DAS personnel, it was decided to define intended beneficiaries in quite narrow terms[15]. Therefore, for this study, intended beneficiaries are those seniors who received the end result of a service sponsored by a funded project (e.g., received meals from a meals-on-wheels service, attended a foot care clinic) or who participated in an activity sponsored by a project (e.g., a choir, a social club, a fitness class, training on nutrition and other health issues for their personal knowledge)[16].

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[14] All references to provincial/territorial representatives or respondents refers to the interviews undertaken with provincial/territorial government representatives.

The objective of the *general public clients survey* was to gather information on the opinions held about the DAS by individuals who have requested (via phone, facsimile or other medium) specialized advice, information, materials or referrals from the Division. Their opinions were also obtained about the top issues facing seniors and regarding the level of government support for different areas, as was done with the *survey of intended beneficiaries*. Some of the respondents contacted for this survey were on the DAS and/or NACA mailing lists. Therefore, these respondents represented a wide range of interests from individual seniors, health professionals and service providers to academics and researchers.

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15. The purpose for using a narrow definition was that it was important to ensure that interviews were conducted with (a) seniors who (b) had received a service or participated in a funded activity. It was believed that those seniors who received, or who participated in, the end result of an activity would be in the best position to comment on the impacts of the projects on their health, well-being and independence.

16. Conversely, individuals who would not qualify as intended beneficiaries would be non-seniors and seniors who may not have been the direct recipient of the project's services or activities (e.g., seniors who helped in the design or delivery of the project, or seniors who received training to provide services to other seniors). This definition was established in consultation with the client and can be found in the letter to project sponsors prepared by the Evaluation Group at Health Canada, June 17, 1996 (See Appendix G).

(a) Instrument Design

The questionnaires for both surveys were developed by Ekos in close consultation with the client. They were entered into the CATI software and pretested. The pretest occurred on July 25, 1996, and was conducted with 10 respondents from each survey sample. The pretest was conducted to ensure that the clarity and flow of the survey instruments was reasonable. Pretesting also serves to check the CATI programming for skip errors and logic. The questionnaire for the survey of intended beneficiaries and the survey of general public clients are presented in Appendix F. For both surveys the interviews lasted 21 minutes on average.

(b) Sampling

Intended Beneficiaries

The sample frame for the survey of intended beneficiaries was a challenging task as no list of project participants had been compiled. Hence it was necessary to contact project sponsors and attempt to develop a sample frame. The Evaluation Group undertook to gather the names of seniors who fit the description outlined above. The community funded projects randomly sampled for the file review also served as the projects whose intended beneficiaries would be contacted.

The activities of the sampled projects varied from addressing elder abuse issues, transportation and social activities to providing training for caregivers and providing education/information to seniors.

Contact names were identified for each of the 265 projects that were sampled. The Evaluation Group sent each contact a package which included a cover letter (Appendix G), a reply form and a postage paid return envelope. The letter explained the nature of the evaluation and requested each project contact to supply a maximum of 20 names (to be entered in a standardized manner on the form provided). A total of 1,538 names were provided, representing 91 projects out of 265 (or 34.3 per cent). The response rates by program and by year of completion are presented in Table 2.3 and 2.4.

TABLE 2.3
Number of Lists Received by Program

Program	# Projects Requested	# Projects Received	Response Rate
NH:PA	45	12	26.7%
NH	130	49	37.7%
SIP	70	26	37.1%
Ventures	20	4	20.0%
Total	265	91	34.3%

While project contacts were asked to choose names at random to ensure representativeness, only 40 per cent of the names were selected in this fashion. This might be due to several factors:

- ☐ some of the projects had fewer than 20 intended beneficiaries and, as a result, all the names were provided (hence, also considered to be representative);
- ☐ contacts knew that some of the participants of their projects were too sick to be interviewed over the phone (e.g., advanced Parkinson's disease, Alzheimer's disease);
- ☐ contacts did not have the names of all the participants in their activities (e.g., seniors who received services in a community hall); and

- ☐ contacts wanted to have authorization from the seniors before adding their name to the list — as this could have taken a lot of time, they only contacted those seniors who were easy to reach.

TABLE 2.4
Number of Lists Received by Year of Completion

Year of Completion	# Project Requested	# Project Received	Response Rate
1992	19	8	42.1%
1993	34	10	29.4%
1994	28	14	50.0%
1995	57	22	38.6%
1996	73	22	30.1%
1997	52	15	28.8%
1998	2	0	0.0%
Total	265	91	34.3%

A total of 1,229 names were entered into the CATI system for use as the sample. Of these, 532 were from random lists (i.e., all of the names which were submitted) and the remaining 697 were from non-random lists. Names were selected from the non-random lists in the following fashion:

- ☐ all names were selected and entered into CATI where the list had 20 names or less;
- ☐ where more than 20 names were on the list, 20 were selected randomly and entered into CATI; and
- ☐ names were excluded where they were illegible or it was indicated that the individual did not speak English or French.

The breakdown of the cases by program is presented in Table 2.5.

TABLE 2.5
Sampled Names by Program for Intended Beneficiaries

Program	Number	Per cent of sample
NH:PA	144	11.7%
NH	676	55.0%
SIP	341	27.7%
Ventures	47	3.8%
Other/not specified	21	1.7%
Total	1,229	100%

General Public Clients

The sampling for the general public clients was more straightforward. The Division maintains a list of individuals who contact it to obtain information, publications, advice and referrals. The list categorizes correspondence into three categories: that which goes out under the name of DAS; that which goes out under the name of NACA; and that which is produced on behalf of the Minister. It was decided that only those names that received information from DAS and NACA in the last two years would be contacted as they would be more likely to be familiar with the Division and to remember the contact. When compiling the list, the Division also consulted the actual correspondence files (i.e., hard copies) in order to select pertinent client interactions (e.g., include requests for information but exclude requests for publications as the interaction would have been extremely brief) and to obtain information on clients' coordinates (e.g., address). A total of 390 names were collected in this fashion and entered into CATI. An additional 2,249 names and phone numbers were provided from the Division's mailing list. These names and numbers were then sorted randomly and the top 1,750 were imported into the CATI software. Therefore, a total of 2,140 names and phone numbers composed the final sample for the survey of general public clients.

Survey Logistics and Response Rate

A team of twenty fluently bilingual interviewers conducted the survey. Every shift was supervised by a minimum of two shift supervisors. The survey manager was also present on all shifts. Interviewers and supervisors were trained on the study issues and the survey questionnaire items. As well, all had previously received training on telephone interviewing techniques and survey administration procedures. A senior consultant involved with the evaluation was available on-site during the first day of the survey and by phone for the rest of the field work to provide any additional information that became apparent that the survey team required. The Project Manager was also available to the survey team during the entire running of the field operation.

In attempting to make contact, no respondent was called more than once per day unless otherwise requested by the respondent. If an interviewer was unsuccessful in contacting a respondent on two consecutive days, an evening attempt was made. Attempts to reach the respondent on a Saturday were also made. No respondents were called after 8:00 p.m. in their own time zones unless formally requested by the respondent. Appointments were made with potential respondents who expressed a wish to participate at a more convenient time. Respondents were called a maximum of ten times. After the tenth unsuccessful attempt to reach a respondent, the case was retired from the sample.

Table 2.6 presents the response rate for each survey. The attrition rate for the survey of general public clients was 30 per cent, resulting in a response rate of 85 per cent of the functional sample (301 completed interviews). The refusal rate was

15 per cent. Of the completed interviews, 124 of the names originated from the enquiry lists, while the remaining 177 originated from the mailing lists.[17] All calls that were not fulfilled during the running of the survey (e.g., no answer, attrition) were removed from the functional sample.

The sample attrition rate for the intended beneficiaries was 35 per cent. This slightly higher level of attrition can be attributed to the fact that lists submitted by one project was made up of the nurses providing the service rather than the recipients of their care, and another project which seniors registered for, but never ran. Along with these factors, the higher attrition can also be attributed to the fact that a higher proportion of this sample had either died or were incapable of participating due to illness. The total number of completions was 553. This results in a response rate of 85 per cent. The total number of refusals was 96. Therefore, the refusal rate was 15 per cent. These results are also presented in Table 2.6.

The reader will note that the proportion of numbers retired (not due to attrition) is considerably higher for the survey of general public clients than the survey of intended beneficiaries. This difference can be attributed to the fact that fewer numbers were required to reach the desired number of interviews. That is, because the desired number of interviews was achieved using the 356 numbers in the functional sample and the 646 numbers retired due to attrition, it was not necessary to pursue the 1138 remaining numbers any further.

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[17] While the initial quota required 175 interviews to originate from the enquiry lists, the small size of the available sample made this impossible. The shortfall was made up by doing additional cases from the mailing list.

TABLE 2.6
Response Rates for the Survey of Intended Beneficiaries and the Survey of General Public Clients

	Survey of Intended Beneficiaries	Survey of General Public Clients
Total Sample	1229	2140
Attrition		
Unavailable for duration of survey	20	79
Call limit attained (# of call-backs = 10)	20	12
No knowledge of involvement with DAS/S	80	48
Language difficulty	71	7
Ineligible	90	46
Phone number not in service	101	446
Deceased	52	8
Total attrition	434 (35%)	646 (30%)
Other numbers retired (not due to attrition)		
No answer/busy	143	1130
Appointment set (then not needed)	2	8
Incomplete interview	1	0
Total	146 (12%)	1138 (53%)
Total Functional Sample	649 (53%)	356 (17%)
Refusals	96 (15%)	55 (15%)
Completions	553	301
Response rate (Completions/Functional Sample)	85%	85%

(c) Respondent Characteristics

Intended Beneficiaries

The socio-demographic characteristics of the respondents to the survey of intended beneficiaries are presented in Table 2.7.

TABLE 2.7
Socio-Demographic Profile: Intended Beneficiaries

Characteristic	Per Cent
Sex	
Male	31
Female	69
Age	
65-69	26
70-74	36
75-79	25
80 +	13
Marital Status	
Married/Common law	49
Widowed	39
Single	5
Separated/divorced	6
Education	
Primary school	17
Some high school	22
High school graduate	23
Some post-secondary	9
Community college graduate	9
University graduate	17
Other	2
Don't know/no response	1
Residence	
Private residence	85
Retirement home/institution/other	15
Language	
English	62
French	23
Other	15
Current Financial Situation	
Can meet needs and have money left over for extras	41
Enough to meet needs, but little left over	46
Can barely meet needs	10
Don't know/no response	3
Household Income	
Less than $10,000	8
$10,000 to $14,999	16
$14,999 to $19,999	14
$20,000 to $29,999	19
Over $30,000	23
Don't know/no response	20
Size of Community	
Less than 10,000	37
10,000 to 99,999	29
100,000 to 1 million	23
Over 1 million	5
Don't know/no response	5

The key differences between the respondents from the lists formed randomly and those from the non-random lists were also highlighted. They are outlined below.

The non-random group was less likely than the random group to have completed an undergraduate degree (9 per cent versus 17 per cent) and more likely to live in a small town of 10,000 people or less (54 per cent versus 21 per cent). The non-random group was also more likely to say their income only allows them to barely meet their needs (13 per cent versus 7 per cent). It should be noted that there are interrelations between these three variables such that, for the sample as a whole, living in a small town is associated with lower levels of education and lower levels of education are associated with being barely able to meet ones needs financially. The non-random group was also more likely to have participated in a NH:PA project (14 per cent of the non-random group versus 3 per cent of the random group) while the random group was more likely to have participated in a SIP project (39 per cent of the random group versus 24 per cent of the non-random group).

Despite these sociodemographic differences, there were few other differences between these groups. The only significant differences between these two groups in the findings from the survey were that respondents from the random group were more likely than those from the non-random group to say:

- ☐ that their participation had helped them maintain their health, well-being and independence (82 per cent versus 72 per cent);
- ☐ that they do not receive any assistance from anyone (82 per cent versus 73 per cent); and
- ☐ less likely to feel that overall, in the area of aging and seniors issues, the government should increase its level of support (28 versus 38 per cent).

In general, it appears from these differences that the non-random group may be somewhat more "at risk" than the random group. There may be something inherent in projects involving these individuals that resulted in the sponsors not being able to select names of participants at random, however this cannot be discerned from the available information. At the same time, there were no differences between the random and the non-random groups in terms of their perceptions of the top issues facing seniors nor in terms of their opinions regarding the level of government support for the different areas presented in the surveys.

General Public Clients

The socio-demographic characteristics of the respondents to the survey of general public clients who were seniors are presented below in Table 2.8. Only those general public clients who were 65 years of age or older were asked socio-demographic questions so that comparisons could be made with the respondents to the survey of intended beneficiaries.

The key differences between the respondents who were seniors (n=87) and those who were under 65 years of age (n=206) are highlighted below[18].

Word of mouth and public advertising/flyers or brochures were more important sources of awareness for general public clients who were seniors compared to non-seniors (13 and 26 per cent respectively became aware of the program this way). Respondents who are not seniors were more likely to be interested in research and publications on seniors issues (31 per cent). Conversely, general public clients over the age of 65 were more likely to be interested in medicare and financial/economic issues than non-seniors (26 and 34 per cent respectively).

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[18] It should be noted that eight general public client respondents declined to give their age.

TABLE 2.8
Socio-Demographic Profile: General Public Clients (Seniors Only)

Characteristics	Per Cent
Sex	
Male	31
Female	69
Marital status	
Married	60
Widowed	26
Single	5
Separated/divorced	9
Education	
Primary school	10
Some high school	16
High school graduate	16
Some post-secondary	15
Community college graduate	11
University graduate	32
Residence	
Private resident	93
Retirement home/institution/other	7
Language	
English	48
French	35
Other	17
Current financial situation	
Can meet needs and have money left over	44
Enough to meet needs but little left over	38
Can barely meet needs	16
Household income	
Less than $10,000	5
$10,000 to $14,999	16
$15,000 to $19,999	16
$20,000 to $29,999	11
$30,000 or more	33
Don't know/no response	18
Size of community	
Less than 10,000	23
10,000 to 99,999	33
100,000 to 1 million	29
1 million plus	7
Don't know	8

Seniors were more likely to state that they did not know whether other sources of information or advice were available (26 per cent).

With respect to satisfaction, non-seniors were more likely than seniors to say their contact with the program had met with their expectations (85 per cent compared to 67 per cent). Moreover, non-seniors tended to be more satisfied with their contact with the program overall (85 per cent versus 79 per cent).

In terms of government support and priorities for the future, non-seniors were more likely to favour government increasing its support to low income seniors compared to those 65 years and over (71 per cent versus 53 per cent). Those respondents under 65 years of age were somewhat more likely to favour increasing government support compared to seniors themselves for selected issues (e.g., accessible transportation, home care or home support services, caregiver services).

2.6 Questions on Rethinking Government

Three closed-ended questions were sponsored on an Ekos field exercise as part of *Rethinking Government*, a multi-year, on-going study aimed at injecting a societal perspective into the debate about government renewal. This study was conducted in November, 1996. Previous iterations of *Rethinking Government* have produced findings such as: seniors are more concerned about crime and abuse than the rest of the population; seniors are most concerned about housing and exhibit fears about losing subsidized housing; seniors are more politically literate than many other subgroups of the population; seniors are most concerned about health, particularly in terms of whether they will be able to pay for health care; and have a higher awareness of the fiscal imperatives for the country.

The three closed-ended questions were added to the *Rethinking Government* instrument for the entire sample (2,962 adults). This sample included 276 respondents who are seniors (i.e., 65 years of age or older). The questions which were added are presented in Appendix H and provide information that was compared to key questions from the survey of intended beneficiaries and the survey of general public clients. A summary of the results for these three questions, including differences between seniors and non-seniors in the *Rethinking Government* results as well as differences with the results from the other two surveys, is presented in Appendix I.

2.7 Expert Consultation

Seven experts in the field of aging and seniors were recruited to lend their expertise to the evaluation through a review of the Draft Final Report[19]. The purpose of the consultations with experts was three-fold: to validate and clarify the findings obtained; to provide suggestions for solutions to problems and recommendations for action; and to provide insight into the issues of attribution and relevance.

The experts were chosen from a list of potential names provided by the Evaluation Group and the Division of Aging and Seniors. Some difficulty was encountered trying to find experts who had not received funding from Health Canada under the DAS/S. An additional consideration was that experts chosen for the panel should have had a good knowledge of the health (and socio-economic) programs in Canada. The final group of experts consisted of five experts from Canada, one expert from the United States and one expert from England. The expert from the United States was identified by both the Division and the Evaluation group and the expert from England was identified by two of the Canadian experts enlisted for the panel. In an effort to form a balanced panel of experts, close attention was paid during recruiting to whether Canadian experts had received funding from DAS/S. The end result was that three of the experts had received funding (although these experts are from Canada, they are also known internationally) and the other four had not received funding (of which two are from outside of Canada).

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[19] A list of the members of the expert panel can be found in Appendix J.

The experts' contribution to the study involved reading an information package, responding to a questionnaire (see Appendix K) and participating in a short telephone interview when needed (for clarification of responses). The experts worked on the questionnaire individually. By receiving separate responses, Ekos was able to identify any biases exhibited by experts more easily (e.g., differences between funded and non-funded experts).

The information package sent to the experts contained a review of the evaluation issues, summaries of the research methodologies and a copy of the draft integrated report. They were also sent copies of the technical documents. The package was assembled to minimize the amount of time experts needed to spend in assimilating information.

In all, six questionnaires[20] were received by Ekos. A summary of the results of the expert consultations, including differentiation of the finding by type of expert (i.e., funded, non-funded, international), is included in this report as Appendix L.

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[20] Unfortunately, one of the experts was unable to complete the questionnaire due to illness. However, this expert did provide some information that was taken into account.

2.8 Limitations of the Evaluation

The evaluation of the Health Canada Division of Aging and Seniors/ Seniors Strategy involved the participation of a large number of individuals and the collection of vast amounts of information. Despite the size of the undertaking, it is important to recognize some of the limitations of the evaluation and its findings. These limitations are described below.

- ☐ The resources (i.e., both time and financial) allocated to the evaluation resulted in third-party opinion serving as the primary source of evidence for several of the evaluation questions. The third-party opinion included consultations with key stakeholders of the DAS/S, namely Health Canada personnel (both at Headquarters and in the regions) as well as seniors organizations, funding recipients and non-funded applicants. These individuals all have a vested interest in the DAS/S and so the potential for stakeholder bias exists.
  - While direct beneficiaries of the projects, and the initiative overall, were consulted through a survey, no direct measure of impact was available. Hence, the results on impact of the participation in the project are based on retrospective self-report. Their perspective was also obtained indirectly, as reported in project files or by stakeholders in interviews. This restricts the level to which conclusions can be derived concerning program impacts.
- ☐ The file review component was faced with three significant constraints: the allocated resources for this methodological component were modest. Given the number of project files to be reviewed, resources did not allow for tremendous amounts of time to be spent on any one project (i.e., less than half an hour); a number of the more recent projects reviewed were ongoing or had just been completed; and past projects were reviewed in light of current objectives and requirements. Although objectives and requirements changed over the timeframe under review, there has been continuity in many of the objectives of the various programs of the original and renewed DAS/S as they have evolved, up to and including the most recent changes..
  - New Horizons, the Seniors Independence Program and Ventures in Independence were all initiated at different times with each having

their own objectives and program requirements. In 1995, the three were amalgamated to form the New Horizons: Partners in Aging program. With this amalgamation came a reorientation in focus and new requirements. It is by these new objectives that projects within all the programs were evaluated. It is difficult to accurately assess the impact and effectiveness of past programs when different criteria are the yardstick by which they are being measured.

Also, due to the fact that NH:PA is really in its infancy stage having only been initiated a little over a year ago, it is premature to be assessing the impacts of this program.

- Evaluation reports, which would have been useful for determining impacts and effects, were only a requirement of NH:PA and SIP projects. Unfortunately, the majority of these projects reviewed were either ongoing or had just been completed. While projects from other programs did provide evaluation reports, these were provided only by more recent projects, many of which were ongoing or just recently completed.

Although there were limitations, every effort possible was made (given the time and resources allocated for this study) to aim for a proper balance in the methods. Whenever possible, participation of respondents who have not, are not or would not benefit from DAS/S funding was ensured. For example, project applicants who had been turned down were interviewed and at least half of the experts on the expert panel have not received funding. Additional efforts made to balance the methods include: a literature review was undertaken; intended beneficiaries and the general public were surveyed regarding impacts rather than relying solely on project files and Health Canada personnel; random sampling was undertaken whenever possible; and provincial/territorial officials were interviewed for their perspective regarding duplication, for example.

Through particular efforts in designing the instruments to be used in the various components, the key evaluation issues have been thoroughly addressed. The consultations with Health Canada personnel as well as with stakeholders have not only provided rich, descriptive detail about the programs and activities of the DAS/S, but have also provided valuable insight into how the programs and activities are actually working across the country, including their perceived impacts and effects. They also have substantial expertise in the area of seniors and aging and are up to date on the current situation of this population sub-group as well as issues of concern to them. Their opinions, combined with knowledge gained through the file review, literature review, data review and the surveys, will be invaluable when making decisions regarding the future of the DAS/S.

CHAPTER

3 PROGRAM RELEVANCE

3.1 Continuing Need for and Relevance of DAS/S

As in most parts of the world, the Canadian population is slowly aging. According to Statistics Canada, the number of seniors almost tripled between 1951 and 1991 (Desjardins, 1993) and census data indicate that by 2036, seniors could double their current share of the population. It is projected that by 2036, 23.2 per cent of the population will be over 65 years old. As we will see, some observers find that this aging process in itself justifies the existence of a government unit responsible for seniors in order to prepare the ground for tomorrow. Many statistics reviewed for the purpose of this evaluation and presented in this chapter also indicate that today's seniors have specific needs that require attention and, for many, these also justify specific government interventions. Still, the relevancy of the federal government's role in this area should not be taken for granted given the provincial/territorial responsibilities in this domain.

This chapter will review seniors' needs as indicated in the literature and will present and discuss the main findings of this evaluation study on the continuing relevance of the DAS/S. More specifically, this chapter will provide answers to the following questions: What are the needs of seniors? Why do seniors need to be helped? Why should the federal government intervene? The documents reviewed for this evaluation study and its interview and survey results provide evidence on the needs of seniors and the relevance of government intervention on seniors issues.

(a) Needs of Seniors and Relevance of DAS/S

Although Canadian seniors do not form a homogenous group in itself, the statistics reviewed indicate that in general, seniors and seniors' needs are in many ways different from the rest of the population. As indicated in the following paragraphs, seniors have less income than other adults, have more and different health needs and require increasing amounts of assistance as they age.

Needs According to the Literature

The public pension system now provides financial independence to most seniors, yet statistics indicate that the poverty rate among seniors is still higher than that of other age groups. According to calculations tabulated by Lochhead and Shillington for the Canadian Council on Social Development on the 1991 census data, 19 per cent of seniors live below the poverty line (i.e., low income cut-off), a rate higher than the average for the total population (16 per cent). The same source indicates that the poverty rate is higher for unattached individuals of all age groups and this is especially true for seniors: 41 per cent of unattached seniors live below the poverty line, compared to 35 per cent of those aged less than 65 years.

Other calculations suggest lower poverty rates among seniors but also indicate that the economic situation of seniors has improved significantly over the years. Between 1980 and 1990, the percentage of senior couples with incomes below the low-income cutoff (poverty line) decreased from 13 per cent to four per cent (National Advisory Council on Aging, 1993e). The same source indicates that the percentage of unattached seniors below the poverty line has dropped from 53 per cent to 26 per cent for men and from 60 per cent to 38 per cent for unattached senior women. The authors note, however, that "many seniors still hover on the margins of poverty and would join the ranks of the official poor if the low-income cutoff was shifted slightly upwards".

These numbers also show that the economic situation varies according to sex. Income of males and females of all age groups over 45 differ significantly according to Statistics Canada (Table 3.1): more senior men (59 per cent) have annual incomes greater than $20,000 than women (40 per cent). This can be explained by past professional occupations of each sex. As stated by Baker (1988), poverty in old age for women is often the result of a lifetime of discriminatory treatment or lower status.

Other sources show that seniors as a group also have extensive health needs. There is, however, no consensus on how much seniors cost the health care system with estimates ranging from 20 per cent to 50 per cent of health expenditures (National Advisory Council on Aging, 1994). According to the 1991 General Social Survey, 72 per cent of seniors rate their health as being excellent, yet many statistics show that as a group, seniors have greater health concerns than non-seniors. Results from the Elder Monitor tend to show that seniors and especially older seniors experience more health problems that those aged between 50 and 64 years old (Table 3.2) (Synergistics Consulting (Toronto), 1996). Documents from NACA (National Advisory Council on Aging, 1993c) indicate that the physical or mental disability rate was 47 per cent for senior women and 44 per cent for senior men in 1987. In general, the disability-free life expectancy (average number of years one could expect to live without disability) decreases steadily with age (Desjardins, 1993). In 1986, it was estimated that at the age of 65, one could expect to live 8.8 disability-free years (8.1 for men and 9.4 for women).

TABLE 3.1
Household and Personal Income

	< $10,000	$10,000-$19,999	$20,000-$39,999	$40,000 +
45+				
Total	9%	22%	30%	39%
Men	6%	19%	30%	45%
Women	12%	24%	31%	33%
45-64				
Total	7%	14%	28%	51%
Men	6%	12%	26%	56%
Women	8%	15%	31%	46%
65+				
Total	14%	38%	34%	14%
Men	7%	34%	40%	19%
Women	19%	41%	30%	10%
80+				
Total	22%	38%	27%	9%
Men	15%	34%	37%	12%
Women	27%	41%	21%	7%

Source: Statistics Canada, Survey on Ageing and Independence, 1991b.

TABLE 3.2
Presence of Diagnosed Conditions

Diagnosed Condition	Heart	Arth	Skeletal	Joint	Diabetes	Lung Disorder	Cancer	Other	None
50-64	23%	20%	17%	8%	6%	6%	3%	18%	33%
65+	40%	32%	20%	10%	11%	8%	8%	17%	17%
80+	42%	34%	16%	6%	19%	10%	6%	25%	16%

Source: Synergistics Consulting (Toronto), Elder Monitor, 1996.

According to Statistics Canada's General Social Survey (1991), seniors in general spend more nights in health care institutions than do individuals of other age groups. In 1990, 17 per cent of seniors over 65 spent at least one night at the hospital (19 per cent for men and 15 per cent for women) compared to 11 per cent for the population aged over 15.

Seniors are hospitalized more often than middle-aged adults for most kinds of illnesses. These statistics show that their global hospital needs tend to change with age. As indicated in Table 3.3, diseases of the respiratory system represent six per cent of all cases of hospitalization for men aged between 45 and 64, but account for 13 per cent of hospitalization for those aged over 75. The proportion of certain causes of hospitalization also changes with age for women. Hospitalization for diseases of the circulatory system progresses sharply with age for women: while they represent 13.5 per cent of all causes of hospitalization for women aged from 45-64 years, they account for 26 per cent for women aged over 75. These statistics, therefore, suggest that health service utilization not only increases with age, but also changes in nature. According to a text cited by Baker (1988), however, a minority of very old people are using most of the health services provided to seniors.

Health needs generally increase and change in nature with age but research shows that some illnesses will decrease in importance in the future. Baker cites a longitudinal study published in 1987[21] that tends to show that seniors of tomorrow will probably continue to suffer from non-lethal causes of disability such as arthritis, rheumatism and mental disability, but causes of death such as cardiovascular disease may be subject to control. Documents from NACA support this finding: according to a study cited by the Council, coronary heart disease declined 30 per cent

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[21] Simmons-Tropea, D., Osborn, R., "Diseases, Survival and Death: the Health Status of Canada's Elderly." in *Aging in Canada; Social Perspective*, Edited by V. Marshall, pp. 520-537. 1987, cited in M. Baker, *Op. Cit.*

TABLE 3.3
Separation Rate[1] for Persons Aged 45 and Over by Cause of Hospitalization, Broad Age Group and Sex, Canada, Fiscal Year 1993

Main causes of hospitalization	Men						Women					
	45-64 years	% [2]	65-74 years	%	75+ years	%	45-64 years	%	65-74 years	%	75+ years	%
Neoplasms	1194.46	9.5	4017.06	13.2	5656.97	11.0	1603.73	13.8	2596.59	11.5	2903.79	7.2
Diseases of the nervous system and sense organs	398.45	3.2	1075.49	3.5	2073.74	4.0	427.39	3.7	1117.83	5.0	2285.91	5.7
Diseases of the circulatory system	3115.20	24.7	8530.25	28.0	13668.65	26.6	1565.25	13.5	5054.29	22.5	10442.71	26.0
Diseases of the respiratory system	764.11	6.1	2803.72	9.2	66743.17	13.1	792.62	6.8	1922.03	8.5	3777.04	9.4
Diseases of the digestive system	2052.53	16.3	3750.68	12.3	5408.97	10.5	1792.82	15.4	2728.04	12.1	4111.58	10.2
Diseases of the genitourinary system	774.88	6.1	2285.44	7.5	3423.74	6.7	1224.03	10.5	1274.29	5.7	1345.26	3.3
Diseases of the musculoskeletal system	773.57	6.1	1280.57	4.2	1538.93	3.0	836.94	7.2	1663.02	7.4	2096.07	5.2
All causes	12605.85		30414.94		51478.39		11611.73		22499.94		40197.04	
Average length of stay (in days)	9.9		14.0		20.6		10.2		15.7		28.1	

Source: Laboratory Centre for Disease Control, based on data from Statistics Canada (Hospital Statistics)

[1] Separation rate: the number of hospital separations during a given year divided by the average population for the year (per 100,000)

[2] Percentage of all causes of hospitalization. Only main causes are shown on table, which is why percentage of column does not add up to 1, i.e., 100 per cent.

for senior males and 35 per cent for senior females between 1971 and 1986 (National Advisory Council on Aging, 1993c). Advancements in science and preventive measures are seen here as key explanations for this improvement. As mentioned before, diseases of the circulatory and respiratory systems remain, however, important health problems of seniors of today. As shown previously, seniors still require extensive health services for these diseases. Measures may help prevent these illnesses and other diseases: physical activity has been linked to the prevention of several chronic illnesses and can reduce the disabling effects of others (Health Canada, 1995c; Sheppard, 1993). Research cited by Addleman (1995) also shows that seniors can preserve and enhance their intellectual capacity through mental exercise. This may well be an effective measure to help seniors take care of themselves and other seniors longer without outside assistance.

Regarding security and abuse, although seniors are less often victims of violent crimes than the rest of the population, they tend to express higher levels of fear of victimization and report crime more often. Adults aged over 60, however, were victimised (by assault, robbery or other violent offenses) by immediate family other than their spouses more often than individuals from other age groups (18 per cent versus 11 per cent), particularly by their children. This could be because many younger people who are victimized are not old enough to have children who could perpetrate violence against them (1988-91 data) (Trevethan, 1992).

As suggested by the data presented in Table 3.4, seniors require more assistance as they age: 57 per cent of people aged between 45 and 64 report receiving some assistance and this percentage rises to 73 per cent for those aged 80 or more. Data also indicate that the type of assistance required by senior women most frequently is transportation.

Data cited by NACA (National Advisory Council on Aging, 1993h) indicate that 87 per cent of senior couples own a car. There are, however, significant differences between men and women: 80 per cent of senior men have a drivers licence, compared to only 37 per cent of women (Statistics Canada, 1993a). It must be noted, however, that transportation can be a problem for small-town seniors. NACA documents report that between 25 and 30 per cent of small town seniors do not drive a car and very few small towns have collective transportation services such as buses or taxis (1990 data). This may partly explain the high percentage of transportation assistance received as reported in Table 3.4.

TABLE 3.4
Assistance

	% Receiving Assistance	Type of Assistance Received			
		Housework	Meals	Transportation	Emotional Support
45+					
Total	58%	35%	30%	30%	35%
Men	55%	37%	37%	22%	31%
Women	62%	33%	23%	36%	39%
45-64					
Total	57%	35%	32%	27%	38%
Men	54%	38%	38%	23%	33%
Women	59%	32%	26%	32%	42%
65+					
Total	61%	36%	26%	33%	30%
Men	56%	37%	34%	20%	26%
Women	66%	35%	20%	43%	33%
80+					
Total	73%	50%	33%	49%	33%
Men	70%	49%	39%	34%	29%
Women	75%	51%	29%	57%	25%

Source: Statistics Canada, Survey on Ageing and Independence, 1991b.

Although transportation may be a problem for many seniors, most still prefer living independently (Walker, 1991). According to data from Statistics Canada cited in NACA documents (National Advisory Council on Aging, 1993i), the percentage of seniors living in institutions has decreased between 1981 and 1991. Numbers cited in this source suggest that younger seniors are living independently longer: between 1981 and 1991, the percentage of institutional residents aged over 74 (i.e., the older seniors) rose from 82 per cent to 85 per cent, while the percentage of seniors living in institutions overall decreased from eight per cent to 6.4 per cent.

Many of today's seniors, however, live alone and data show that more "older" seniors live alone than younger ones. According to the Survey on Ageing and Independence (Statistics Canada, 1991b), 46 per cent of seniors over 80 and not living in an institution live alone[22]. This percentage rises to 59 per cent for women. This appears significant if one considers that social isolation, widowhood and feelings of rejection are among some of the explanatory causes of suicides among seniors (Ministère de la santé et des services sociaux, 1991). It is also unclear whether all of those seniors living alone are totally capable of doing so: according to the Canadian Study of Health and Aging, 29 per cent of those with dementia in the community were living alone in 1991 (an estimated 34,800 in Canada). The study also suggests that three thousand people with dementia living in the community had no caregiver at that point in time (Canadian Study of Health and Aging, 1994).

Many seniors call upon others for assistance. Seventy-five per cent of care received by community dwelling seniors is provided by family, friends and neighbours rather than by formal care providers (Marshall, 1993). Many studies in Canada and abroad show that caregivers are most often women, especially wives and daughters[23]. The spouse/partner (44 per cent) tends to be the primary source of assistance, followed by daughters (34 per cent) (Statistics Canada, 1991b).

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[22] 18 per cent of seniors aged 80 and over lived in long term institutions in 1994 (Tully and Mohl, 1995).

[23] See A. Walker (1991), Gee, E. and S. McDaniel (1993), M. Smith and C. Longino (1994), for example.

Women in general are more likely to provide informal support and most assume the costs associated with this. These costs can be economical, physical, emotional and/or psychological. According to a recent study, this is especially true for those who take care of seniors who suffer from dementia: seniors who are living in the community and suffer from dementia are more likely to have a caregiver who is a female (75 per cent) than are those without dementia (66 per cent) (Canadian Study of Health and Aging, 1994). This research also indicates that six per cent of all informal primary caregivers were employed, thus having a dual role. The authors of this article cite many studies that associate distress, depression and other emotional changes with caring for a senior person with dementia. There is also some evidence that physical health may be affected by providing care. The study shows that 10 per cent of caregivers report requiring additional services (30 per cent of those caring for someone with dementia); the greatest single demand is for day care (nine per cent of caregivers) (Canadian Study of Health and Aging, 1994). Female caregivers in general are exposed to certain health risks and some openly express some need for assistance but as Walker (1991) explains, this sexual division of caregiving help is still socially accepted.

The future of formal care is directly dependent on future public spending. Social factors may, however, have more important effects on *informal care*: trends in demographics, family structure and labour-market participation suggest that informal sources of care may also be endangered. A higher proportion of seniors, a trend toward smaller families — that is, with fewer children who are potential caregivers — and a higher female participation rate in the labour market may limit informal sources of senior care. This leads many specialists[24] in the field to say that there will probably be a higher demand for formal care for seniors tomorrow than there is today. These factors and the rising divorce rate may limit the number of caregivers[25] and spur demand for formal care and should also be considered by today's and tomorrow's policy makers.

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[24] Such as Chipperfield (1994), Gee and McDaniel (1993), Smith and Longino (1994), for example.

Gee and McDaniel (1993) note, however, that policy-makers have taken informal sources of caregiving for granted and caregiver-support strategies should be developed. For them, support should be targeted towards middle-aged women who form the bulk of caregivers but are in need of assistance themselves. For Walker (1991), there could be, at least in the U.K., better coordination between formal and informal caring mechanisms without a rigid division between formal and informal sectors. Change should be initiated in professional values and attitudes within the formal sector, pursues the author, if a partnership between the formal and informal sectors is to be developed. This is primarily a matter of increasing accountability of professionals to both older people and their caregivers. A long term goal would be to change the experience of welfare care from a passive to a more participatory role (on the part of clients and caregivers) in the definition of need and policy responses to it. Still, there will always be an important role for professional groups, according to Walker (1991).

Training in caregiving should also be developed, according to Smith and Longino (1994). Notwithstanding caregivers' characteristics, it is suggested that the abilities and skills of informal caregivers be developed in order to reduce the strain that has been and will be forced by the sociodemographic and economic trends discussed earlier. The authors note that educational gerontologists should have a much larger role to play in meeting this need for information.

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25. Thus putting more pressure on those who will assume caregiving responsibilities in the future. Some American observers even go to say that "Granny dumping" at hospital emergency rooms may be the social epidemic of the next century in the U.S.A., as stressed families are unable to cope with parents or relatives living longer than ever. In an informal survey led by the American college of Emergency Physicians, emergency rooms had an average of eight abandonments a week (Addleman R. B., "Eldercare: Out of the Institution and into the Community" in *Healthcare Forum Journal*, May/June 1995, p. 59).

Some authors suggest that the rising number of seniors and demand for formal support may spark friction between generations. As Walker (1990: 387) points out: "Ageing is seen as a problem to the extent that it poses a potential threat to the economic growth and, by implication, social cohesion". For some this may justify special government interventions to promote a positive image of seniors and positive attitudes towards them. Non-seniors tend to evaluate aging as more problematic than do seniors; publications cited in Seccombe and Ishii-Kuntz' article (1991) indicate that many American children, adolescents, students and adults view seniors as being weak, in poor health, dependent, asexual, socially isolated, unattractive and of low competence. Non-senior participants in focus groups held in Canada (Tandemar Research, 1988) also talked more about poor health, financial difficulty and loneliness among seniors than did the seniors themselves.

It seems that only a minority of seniors feel that aging is perceived negatively among other members of the population; according to the survey of intended beneficiaries undertaken for this evaluation study, 15 per cent of seniors tend to say that non-seniors' perceptions of aging and seniors are negative, 35 per cent think they are rather positive, while 45 per cent say that non-seniors have mixed views. The views of the general public clients are less positive: one general client in five believes these perceptions are positive, and about the same proportion (18 per cent) believes views are negative. The majority of general public clients — 60 per cent — believe non-seniors have mixed views. As mentioned earlier, most seniors believe that more work should be done to inform the general public about seniors and their contribution to society (*National Advisory Council on Aging*, 1993b). According to the survey conducted for this evaluation, however, this should not be the highest priority for government. Seniors (intended beneficiaries and general public clients) indicated that government should increase or maintain its support to services related to health, home care, housing and transportation, before improving the public image of seniors. Still, 41 per cent of seniors from the intended beneficiaries group and 45 per cent of the

TABLE 3.4
Most Important Need Among Seniors: *Rethinking Government*
(in percentage) (1)

Most Important Need		Age groups				Region					
	Total n=2,962	**16-29 n=635**	**30-44 n=1,038**	**45-64 n=997**	**65 + n=276**	**Atlantic n=399**	**Quebec n=984**	**Ontario n=872**	**Man/ Sask n=203**	**Alberta n=204**	**BC n=300**
Public health care	44	42	46	45	45	48	37	51	46	43	37
Financial security	35	34	36	35	37	36	34	34	37	36	39
Personal safety and security	12	14	10	12	12	9	17	8	14	13	14
Specialized housing	6	7	6	6	3	5	9	5	2	6	6
Specialized Transportation	1	3	0	1	0	1	2	1	0	0	2

Source: *Rethinking Government* '96, Ekos Research Associates

(1) The question being "*Following is a list of needs which may be of importance to seniors in Canada today. Which would you say is the most important need among seniors?*"

senior general public clients indicated that government should increase its support in improving the public image of seniors.

Results from *Rethinking Government* show that all age groups agree that public health care and income security are the most important needs of seniors: as shown in Table 3.4, 44 per cent agree that public health care is the most important need of seniors, followed by financial security (35 per cent) and personal safety and security (12 per cent). There are, however, differences between regions: as shown in the same table, more respondents from the Atlantic provinces (48 per cent), Ontario (51 per cent) and Manitoba/Saskatchewan (46 per cent) than in the other provinces feel that public health care is the most important need for seniors.

Experts who participated in the study were also asked to identify emerging needs with respect to the health, well-being and independence of Canada's seniors. The experts provided a wide variety of comments touching on a number of different issues. According to experts, key emerging issues include:

- ❑ services, issues regarding the "old-old" (i.e., over age 85) who will become an increasingly significant proportion of the seniors population;
- ❑ research and policy to address the income and health impacts of older workers and the prematurely retired;
- ❑ improving long term care quality and exploring alternative care options that feature greater affordability, flexibility and address consumer needs;
- ❑ ethical issues concerning health care and well-being;
- ❑ support to informal caregivers and front-line staff who care for seniors (e.g., training, support, supervision and compensation);
- ❑ dementia;
- ❑ age discrimination;
- ❑ productive roles for longer retirement years; and

- self-help strategies.

Many interview respondents confirmed the importance of health and income needs as well as other emerging needs identified by the expert panel. Other needs identified by the respondents interviewed for this evaluation include:

- quick access to services when needed by the most frail;
- good nutrition;
- adequate housing;
- protection from crime, violence, fraud and scams;
- mental stimulation;
- low cost adapted transportation (e.g., buses with lower steps);
- money to train and provide support/assistance to caregivers;
- information on who to talk to obtain specific information;
- information on places where they can stay when they are no longer able to live independently;
- general continued integration to society by remaining active (with current changes in society regarding families, social security and new technologies, it is important that seniors are not left behind, remain active and continue to contribute to society); and
- a sense of usefulness.

(b) Comparison With Other "At Risk" Groups

Health care is an important need for seniors and many statistics cited in the previous sections tend to show that seniors require more health care and assistance than younger generations. Of course, aging itself contributes to these health needs but other factors are also involved. As health is directly related to income (Baker, 1988), many seniors are exposed to health risks and require outside assistance because of their limited financial and social resources. As outlined in the conceptual framework on seniors at risk written by the Canadian Association on Gerontology (1995), situations of risk may include poor health, abuse, advanced age, low income, lack of support and loss or bereavement. Being in one of these situations, however, does not in and of itself guarantee that a senior is "at risk" as there are other factors at play.

Risk is best understood as the relationship between three elements: risk factors; resources; and life experiences. How these three factors interact with each other will affect the extent to which a senior is "at risk". A senior's personal or social supports, that is, their resources, can counteract the negative effects of risk factors. Still, as mentioned before, statistics show that many seniors experience more health problems and have lower income than the rest of the population. There are, however, other "at risk" groups in the rest of the population. Are seniors more "at risk" than these other social groups? Considering the current financial constraints in government, this is a crucial question. Only a systematic comparison between seniors and other social groups would determine if seniors are more "at risk" than others and this is beyond the scope of the present evaluation study. There are, however, some published statistics that provide a basis for comparisons between seniors, children, immigrants and the Aboriginal population.

Compared to children, the economic situation of seniors is not significantly better: at 19 per cent (see Table 3.5), the poverty rate of seniors 65 and older is not lower than that of children under the age of 15 (18 per cent). While there is not a substantial difference in poverty rates, the significant difference in economic security among seniors and the disproportionate number of seniors who are barely over the poverty line cannot be ignored (Health Canada, 1994a). This is particularly important as these seniors would not be eligible for many programs aimed at seniors living below the poverty line.

TABLE 3.5
Poverty Statistics

	Total (Thousands)	Poor (Thousands)	Dist. of Poor in Total Population	Poverty Rate*
Unattached Individuals — By Age				
Under 65 years	2,400	830	70%	35%
65+ years	880	360	30%	41%
Total	**3,300**	**1,200**	**100%**	**36%**
All Persons By Age				
Under 15	5,500	1,000	24%	18%
15-34	8,500	1,400	34%	17%
35-64	9,500	1,200	29%	13%
65+	2,900	540	13%	19%
Total	**26,000**	**4,200**	**100%**	**16%**

Source: Special Tabulations — 1991 Census. Calculations by Lochhead and Shillington (1996) for the Centre for International Statistics at the Canadian Council on Social Development (CCSD).

* Represents the proportion of the poor who belong to this group.

Healthwise, seniors experience more illnesses than do children[26] and as shown in Table 3.6, health service utilization in terms of visits to a medical doctor and institutionalized nights is higher among seniors than youths aged between 15 and 24. Statistics indicate, however, that young people are more likely to suffer from injuries and that in general, injury rates decline with age (Statistics Canada 1994-95). Finally, while youth suicide rates are high, they are comparatively lower than that of seniors, particularly male seniors (see Exhibit 3.1). According to these statistics, approximately seven out of 100,000 Canadian children between the ages of 10 and 19 committed suicide in 1991 compared to approximately 15 out of 100,000 seniors between the ages of 60 and 69, approximately 16 out of 100,000 seniors between the ages of 70 and 79 and approximately 14 out of 100,000 seniors 80 years of age and over. Thus, as a group, seniors appear to be at greater or equal risk than children.

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[26] Compared to seniors, few children have long-term illnesses such as arthritis, diabetes, heart disease and lung conditions. Less than one per cent of children 14 years old and younger suffer from any one of these conditions. In comparison, eight per cent of seniors over 65 suffer from lung disorders, 11 per cent suffer from diabetes, 32 per cent suffer from arthritis and 40 per cent suffer from heart disease (Synergistics Consulting [Toronto], *Elder Monitor*, 1996). The incidence of cancer for children is also lower than it is for seniors at less than one per cent of children under the age of 19 (Health Canada, 1995i) compared to eight per cent of seniors over the age of 65.

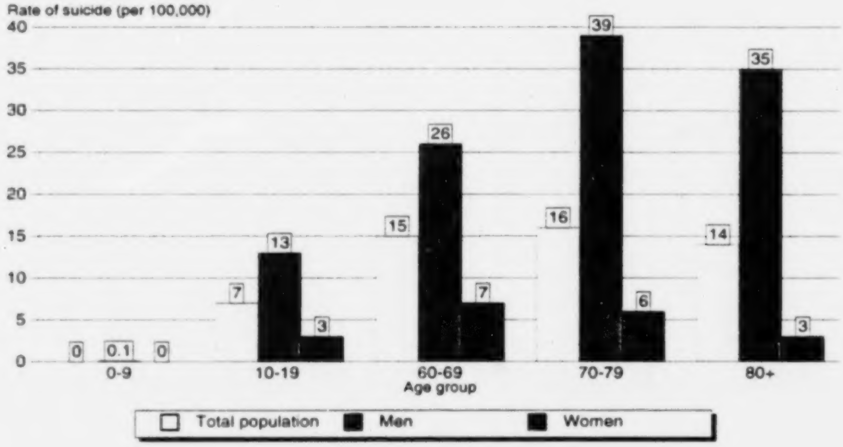
TABLE 3.6
Youth and Senior Health Service Utilization

Age Groups	Number of institutionalized nights in preceding 12 months		
	No nights (%)	1-2 nights (%)	3 + nights (%)
15-24 years	90	4	6
65-74	85	3	11
75+ years	78	4	18
	Number of contacts with a medical doctor in preceding 12 months		
	none (%)	1-2 (%)	3+ (%)
15-24 years	16	45	38
65-74	8	28	62
75 + years	6	21	69

Source: Statistics Canada, General Social Survey, 1991b.

Compared to Aboriginal people, the economic situation of seniors is significantly better. The study on urban poverty conducted by the Canadian Council on Social Development (Lochhead and Shillington, 1996) reported the poverty rate of individuals with Aboriginal origins over the age of 15 in 1991 to be 30 per cent. This is 11 percentage points higher than the poverty rate of seniors over the age of 65.

EXHIBIT 3.1
Suicide Rates of Children, Youth and Seniors in 1991



Source: Santé et Bien-être social Canada, Direction générale des services médicaux, document inédit, 1993. Royal Commission on Aboriginal Peoples, *Choosing Life:* special report on suicide among Aboriginal People. February 1995.

Immigrants may also be considered a potential group at risk. Also, according to the study by the Canadian Council on Social Development, the poverty rate for visible minorities in 1991 was 27 per cent. This is eight percentage points higher than the poverty rate of seniors over the age of 65. Life-expectancy statistics also suggest that Aboriginals are more at risk healthwise than the rest of the general population; life expectancy at birth for Aboriginal women is 73 — compared to 81 for non-Aboriginal females — and 65 for Aboriginal men, compared to 74 for non-Aboriginal males (Department of Indian Affairs and Northern Development, 1989).

In the literature reviewed for this project, there was very little information on whether the health care needs of immigrants were being met. The only study reviewed which examined this issue was a study by Chen *et al.* (1996).

According to this study, there was no indication of health care needs not being met based on immigrant status alone and regardless of years living in Canada.

Thus, based on the literature reviewed for this survey, seniors appear to be exposed to more health risks than children. Compared to the Aboriginal population, however, seniors do not appear to be more at risk. As for immigrants, it appears that there are no comparative studies on the subject which could have indicated if seniors are more at risk than immigrants.

(c) "At Risk" Senior Groups

Available statistics show that from many viewpoints, seniors are exposed to more health risks than children, without necessarily having more income to compensate. As mentioned before, however, the senior population is quite varied and statistics show that an important segment of seniors is definitely more at risk that the rest of the senior population. According to the literature review, three senior sub-groups appear to be more "at risk" than other seniors.

- ☐ As health is directly related to income, there is no doubt that seniors with limited income constitute a major segment of seniors at risk. As indicated earlier, almost one senior in five is considered "poor", a proportion that climbs to 41 per cent among those living alone. As statistics show, these are most often older women.
- ☐ Although they represent less than one per cent of the population[27], health statistics still show that Aboriginal seniors are more at risk than non-Aboriginals; currently, life expectancy at birth for Aboriginal women is 73 compared to 81 for non-Aboriginal females and 65 for Aboriginal men, compared to 74 for non-Aboriginal males (Department of Indian Affairs and Northern Development (DIAND), 1989).

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27. Four per cent of the Aboriginal population were over 65, compared to 10 per cent for the total Canadian population.

- ☐ Seniors living in isolated or rural areas are also considered at risk because they have less access to services, especially public transportation services. Many seniors living in these areas also have less access to specialized health care services and health care in general.

Although all seniors are exposed to health problems, these sub-groups of seniors appear to be more at risk than others. The expert panel generally agreed with these identified sub-groups. One expert also suggested that the older unemployed be added to these sub-groups even though they are not seniors *per se*.

Needs of Seniors and Continuing Need for DAS/S: General Findings

As indicated in the literature, many seniors are exposed to health, social and economic problems and many require more assistance than the rest of the adult population. Does this justify the existence of a division devoted to seniors' issues in the federal government? Is there a continuing need for DAS/S?

According to interview respondents, the needs of seniors include income security, health care (including prevention), social supports (support to seniors to help them maintain an appropriate level of independence), intergenerational relations, ethical issues, participation in society, housing and transportation. Health care and income were mentioned by most interview as well as survey respondents. Survey respondents were asked, among other things, what they consider to be the biggest issues currently threatening the health, well-being and independence of Canadian seniors. According to the results, the three most important issues for both survey respondent types are health care (37 per cent and 57 per cent of intended beneficiaries and general public clients, respectively), income security (26 per cent and 42 per cent) and government cutbacks (19 per cent and 26 per cent).

The importance of health and income security issues is corroborated by most studies reviewed on the subject. The annual *Elder Monitor* (1996) by Synergistics Consulting (Toronto) provides information on seniors' self-identified needs. According to this research, better income or financial security was the top factor that seniors identified as contributing to their well-being (18 per cent). This factor was consistently rated first across gender, marital status and region. Of note is that economic security and health were the two main conditions noted by funded experts as conditions that could be significantly improved by federal government action.

In the *Rethinking Government* survey, people were asked to indicate which of five possible needs which may be of importance to seniors in Canada today they felt was the most important. Forty-four per cent of respondents chose public health care, 35 per cent indicated financial security, 12 per cent said personal safety and security, six per cent selected housing, and one per cent chose transportation as the most important need. Interestingly, there were no differences as a function of age, gender, or education.

According to most interview respondents, these needs have to be addressed and the vast majority agree that there is a continuing need for a federal government division to address them. Expert panellists concurred with this sentiment. Many respondents also justified this continuing need by referring to the fact that the population is growing older and to social trends such as expectations that family support will probably diminish. Many interviewees also feel that the government must prepare for the needs of seniors of tomorrow.

Several experts indicated that the absence of DAS/S would, in time, have a detrimental effect on the lives of Canadians seniors. It was agreed that impacts would not be immediate, however, since the extent to which DAS/S has had a significant *direct* impact on seniors is unclear. What is clearer, at least in the minds of the experts, is DAS/S's catalytic effect in research, advocacy and promotion of seniors and aging issues. Without DAS/S the visibility of seniors and aging issues would lessen. Also, the voice advocating seniors and aging issues would be muted and the identification of emerging issues and responses to dealing with these issues would be diminished. The experts surmised that negative impacts would thus be felt over time and, according to one expert, could eventually lead to increased mortality among older Canadians.

Priority Needs of Seniors: Review of Key Findings

In very general terms, the survey findings as well as the literature indicate that health and income related needs are among the most important for seniors. Many sources also suggest that seniors living alone (especially senior women), senior Aboriginals and seniors living in isolated areas are among those most at risk and would require more outside assistance than other groups. The literature also suggests the following priority needs to be addressed:

- For many seniors, income support appears as a fundamental need.
- Seniors in general and the older seniors in particular have extensive health service needs. As indicated by many statistical sources, many of the older seniors suffer from a number of diseases, namely those related to the circulatory and respiratory systems, but also from cancer and musculoskeletal ailments.
- Considering that many seniors live alone or want to remain independent as long as possible, caregiving needs and general assistance are also important and literature shows that these needs will be greater in the future.
- Seniors also need to be informed on the most up-to-date information and research findings that could improve their living conditions. This

information covers a wide range of issues, including methods of self-care and care for others.

Of course, needs such as housing and transportation could be rightfully added to these but, for the purpose of this evaluation, these three group of needs would appear to be most significant. Actions such as direct services and care, prevention, research and information-related activities are required to properly address them. What then should be the role of DAS/S in addressing these needs and other seniors needs? What actions should be undertaken by the DAS/S? Considering the current division of responsibilities between the federal and provincial departments, this would appear as a crucial evaluation question.

3.2 The Role of Health Canada and DAS/S

The literature review, survey and interview results indicate a number of seniors' needs and issues. For most respondents, the federal government has a role in addressing these needs and issues. As indicated in the following section, although some respondents would prefer another distribution of responsibilities, most tend to agree that a seniors division within Health Canada has a legitimate role to play in addressing seniors needs.

Also as indicated in the preceding sections, health is a major seniors issue and this may be viewed as a key justification for locating a seniors division within the federal government under the mandate of Health Canada. Before reviewing the respondents' views on this, the Department's mandate and the Population Health Strategy within Health Canada will be reviewed to better assess the logic of this distribution of responsibilities.

(a) Health Canada's Mandate

The *Department of Health Act* (Bill C-95, recently passed by Parliament, July 19, 1996a) outlines the role to be played by Health Canada with respect to the health of Canadians. Some specific responsibilities as outlined in the *Act*, and which are consistent with Health Canada's role within the DAS/S, are as follow:

- the promotion and preservation of the physical, mental and social well-being of the people of Canada;
- the protection of the people of Canada against risks to health and the spreading of diseases;
- investigation and research into public health, including the monitoring of diseases; and
- cooperation with provincial/territorial authorities with a view to the coordination of efforts made or proposed for preserving and improving public health.

The key difference between the *Department of Health Act* and the previous *Department of National Health and Welfare Act* (R.R. Chapter N-9, s.1), which was in place when the Seniors Strategy was initiated, is that income security programs (i.e., Canada Pension Plan, Old Age Security, Guaranteed Income Supplement) and the cost sharing of welfare programs (i.e., through the Canada Assistance Plan) are no longer the responsibility of Health Canada. Income security programs were handed over to Human Resources Development Canada (HRDC) in June 1993. Although this change has raised the question as to whom should be responsible for the programs under the Seniors Strategy, Health Canada has continued to oversee this initiative under its mandate.

Health Canada's role, as described in the *Health Canada 1995-96 Estimates, Part III*, is to help Canadians maintain and improve their health. The emphasis is on fostering healthy individuals, healthy families and a healthy society, with an emphasis on disease prevention and health promotion. The work of the Department includes:

- ☐ financial support to provinces and territories for insured health care;
- ☐ cooperation with provinces and territories in health system renewal and in addressing identified health-related issues;
- ☐ health protection and consumer safety by refocussing and strengthening Canada's health intelligence network;
- ☐ the fostering of public health research;
- ☐ activities aimed at improving health care and health services in Canada;
- ☐ activities aimed at disease prevention and the promotion of good health; and
- ☐ activities targeted at issues affecting specific groups in society (e.g., women, children, seniors).

Given the constitutional division of responsibilities, a large proportion of the work of the Department involves collaboration with provincial and territorial authorities in efforts to maintain and improve the health of all Canadians. While it is true that the constitution confers most health responsibilities to the provinces/territories, only the federal government could assume a national policy and coordinating role in the area of health, as well as establish national standards, guidelines and strategies.

The activities of the DAS/S are clearly relevant to the Department's legal mandate, as described above, as well as its overall mission — to help the people of Canada maintain and improve their health. Aspects of the DAS/S are also directly related to specific Departmental goals, as stated in the *Health Canada 1995-96 Estimates,* *Part III* — for instance: to foster active health system partnerships with provinces, territories and others; to give increased priority to initiatives that redress the most significant health inequalities in Canada; and to provide leadership on health promotion, disease prevention and health strategies.

Population Health Strategy

As one of its four main business lines, Health Canada has adopted a Population Health Strategy (Health Canada, 1995e). The Health Promotion and Programs Branch spearheads the business line on population health and almost the entirety of the DAS/S resides within this branch. The population health approach focuses on the entire range of individual and collective factors and conditions (including individual characteristics, social and economic factors, and physical environments), as well as the complex interactions among these, that determine the health and well-being of Canadians (Federal/Provincial/Territorial Advisory Committee, September 1994). Strategies to improve population health are based on an assessment of all factors and conditions of risk and benefit that may apply across the entire population, or to particular sub-groups within the population. It is also assumed that improving health is a shared responsibility that requires the development of healthy public policies in areas outside the traditional health system, as well as collaboration among different sectors and levels of government. With the current determinants of health model and population health approach adopted by Health Canada, a multidisciplinary unit is no longer at cross-purposes with the Departments responsibilities.

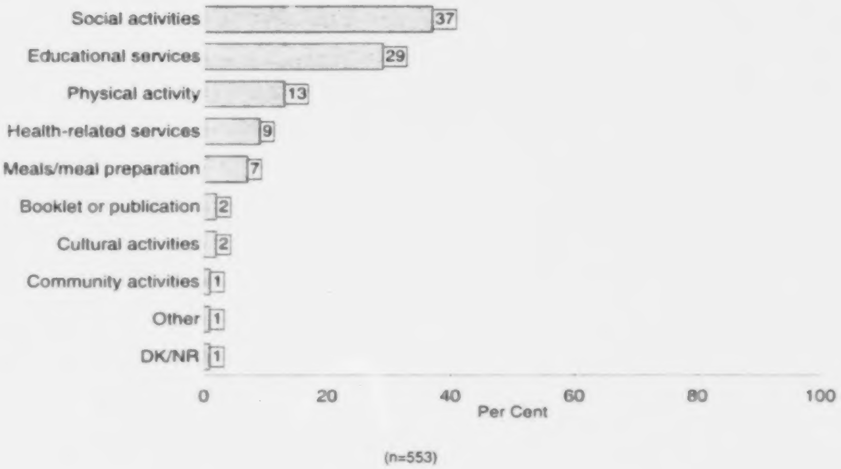
With the Population Health Strategy, Health Canada uses an evidence-based approach to identifying and focusing its investments on the conditions that exert the greatest influence on the health of the Canadian population. This approach also incorporates a life cycle framework, whereby population health programming is tailored to the unique health determinants and needs at three stages of life — children and youth, midlife and later life.

Addressing the Needs: Survey Results

The holistic approach put forward by the Population Health Strategy recognizes the influence of social and other environmental factors on health. In this way, the multidisciplinary approach of DAS/S appears consistent with the strategy. The Division undertakes many activities and assumes many roles that encompass a wide variety of issues; as mentioned earlier, DAS/S activities include coordination and research support activities, as well as project funding.

In the survey of intended beneficiaries, respondents were asked to describe the main activity or service that they received by participating in the program. As shown in Exhibit 3.2, the most commonly cited were social activities (aimed at reducing social isolation and promoting social interaction) (37 per cent), educational services/information sessions (29 per cent) and physical activity/fitness (19 per cent). Nine per cent of respondents participated in health-related services, seven per cent in meals/meal preparation activities, while the remaining respondents participated in other activities (seven per cent). Respondents may have participated in many different types of activities but these results indicate that more seniors have received services of a social or educational nature. According to the survey of general public clients, 29 per cent of those who contacted DAS/S for information or who appear on DAS/S' mailing lists are seniors, indicating information needs which may be met through contact with DAS/S.

EXHIBIT 3.2
Main Activity: Views of Intended Beneficiaries
"What was the main activity of service you received?"



Source: DAS/S Evaluation, Survey of Intended Beneficiaries, 1996.

(b) Relevance of Roles: Interview and Survey Findings

Through DAS/S, the federal government assumes both a coordinating role and a supporting role with respect to research and surveillance activities, policy development, seniors community program development and delivery, as well as information, education and consultation activities. Although some respondents would rather see more emphasis on certain roles and less on others, most respondents in this study tended to agree that in global terms, the federal government's role is relevant for many reasons. Most interview respondents agreed that there is a continuing need to address seniors' and aging issues through at least one of the following roles:

- policy and leadership;

- coordination within the federal government and between the federal government, the provincial/territorial governments and the NGOs;
- information sharing with the provinces/territories and other organizations, and with seniors themselves;
- health promotion and disease prevention; and
- champion of seniors' and aging issues.

For many interviewees, however, there was less consensus on the relevance of the role of the Division regarding research and community-based activities. While most agreed that these roles are relevant for the DAS/S, those who did not expressed the following views:

- A number of Health Canada (HC) officials who tended to speak highly about Health Canada's role in funding community projects tended to view the research activities of DAS/S, particularly SIRP, as somewhat of a weak link. Some suggested that the research was not always in sync with the needs of seniors, and was probably less cost-effective than community funding programs because the impacts on seniors were at best indirect. These views were mostly heard from the regional officials.
- Other respondents from Health Canada, mainly at Headquarters and those involved in research and policy development, as well as those from the Interdepartmental Committee on Seniors Issues and the provinces/territories argued that Health Canada's role in funding community projects should be reduced and redesigned. Some felt that the provinces/territories and community organizations were better positioned to set priorities and implement programs at this level. These respondents felt that Health Canada should only be involved in demonstration and innovative projects, and the dissemination of their results.

This debate did not come up during our interviews with the funded applicant and funding recipients. According to interview results, funding recipients and non-funded applicants are reluctant to see Health Canada and DAS/S reduce or eliminate its support for both community and research projects.

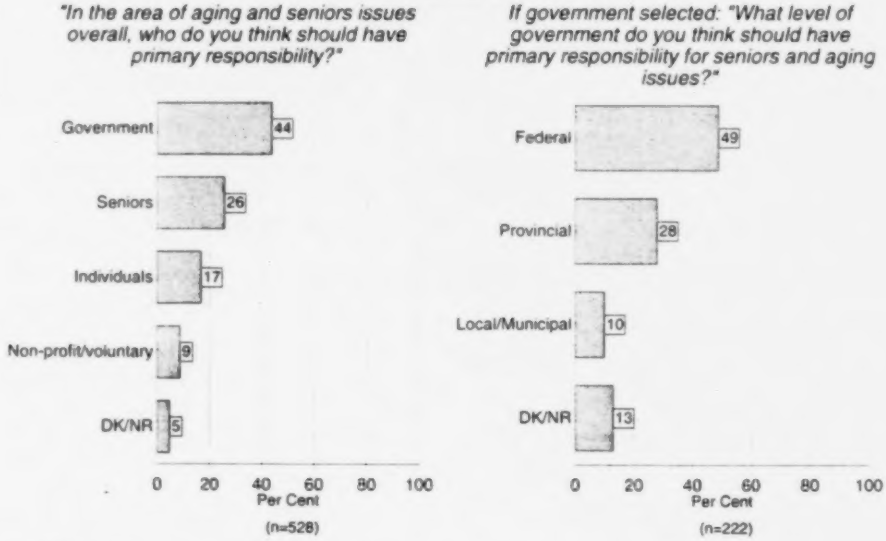
The two respondents from the central agencies mentioned that the federal role and objectives need to be better focused on areas where success can be expected and measured. The appropriateness of the Health Canada role is also questionable, according to these respondents. On the one hand, the Minister is responsible for both health and seniors issues, and health promotion is clearly within the Department's mandate. On the other hand, the focus of DAS/S goes well beyond purely health issues to encompass other issues/programs of more relevance to other federal departments such as Human Resources Development Canada (HRDC) (e.g., social issues, income security, Canada Pension Plan).

Many roles for government were discussed and dismissed by stakeholder respondents. For example, all stakeholders (but one) agreed that the federal government has a continuing role in preserving the health, well-being and independence of Canadian seniors. Regarding society's understanding of seniors, a few stakeholders indicated that it will come naturally as the population ages. Thus, the government is not necessarily viewed as having a role regarding the image of seniors. In any case, this role is expected to decrease in time as the population ages. One stakeholder, however, felt that there is no need for the DAS/S because there is no equivalent for the younger generations: "There is no division for 35 year olds, why is there one for older adults?" This stakeholder suggested that seniors' issues should be integrated into all departments (including Heritage Canada and Human Resources Development Canada) and a Council on Aging formed which would be composed of representatives from different departments.

All the respondents from the expert panel agreed that there is a continuing need for initiatives which enhance the health, well-being and independence of seniors. One international expert expressed some doubts, however, on the relevance of community programs. Another expert suggested that the mandate of DAS/S be expanded to include the older workers or "prematurely retired" workers group. All acknowledged the importance of research and indicated that DAS/S must continue its support in the areas of Alzheimer's disease, osteoporosis, biochemical changes, nutrition and medication. More longitudinal studies should be supported also.

The surveys with intended beneficiaries and general public clients provide an indication of the preferences of these groups regarding responsibility for aging and seniors issues. When intended beneficiaries were asked who should have primary responsibility for aging and seniors' issues, 44 per cent said it should fall to government. Twenty six per cent would like to see seniors with the responsibility and 17 per cent said that it should go to individuals in general (Exhibit 3.3).

EXHIBIT 3.3
Responsibility for Aging and Seniors Issues: Views of Intended Beneficiaries

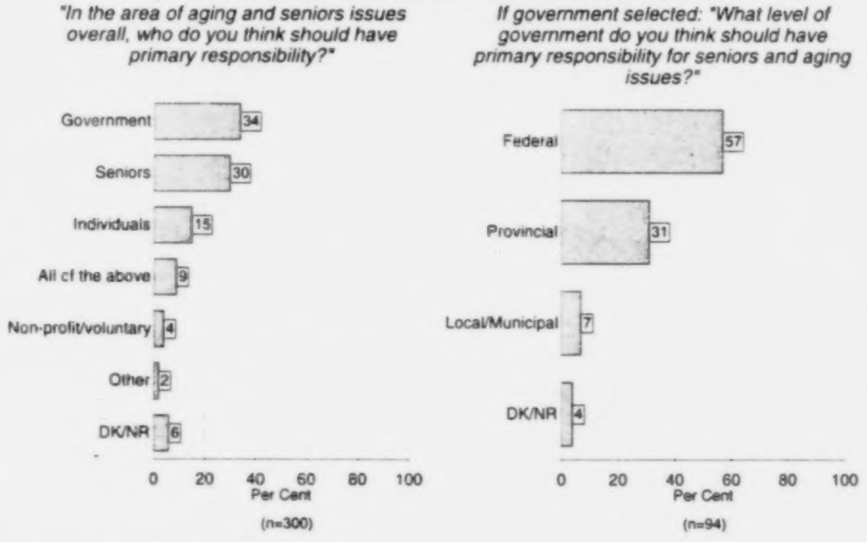


Source: DAS/S Evaluation, Survey of Intended Beneficiaries, 1996.

Of those intended beneficiaries who selected government as having the primary responsibility for aging and seniors issues, just under half (49 per cent) selected the federal government as the level of government which should have primary responsibility. Just under one-third selected the provincial/territorial government and a minority — 13 per cent — chose local or municipal government.

General public clients were also asked who should have primary responsibility in the area of aging and seniors issues overall (Exhibit 3.4). Government was also chosen most frequently by respondents (34 per cent), somewhat less than the intended beneficiaries (44 per cent). Seniors themselves were second (30 per cent believe seniors should have primary responsibility for aging and seniors issues). Individuals and non-profit/voluntary organizations were chosen by 15 and four per cent of respondents respectively.

EXHIBIT 3.4
Responsibility for Aging and Seniors Issues: Views of General Public Clients



Source: DAS/S Evaluation, Survey of General Public Clients, 1996.

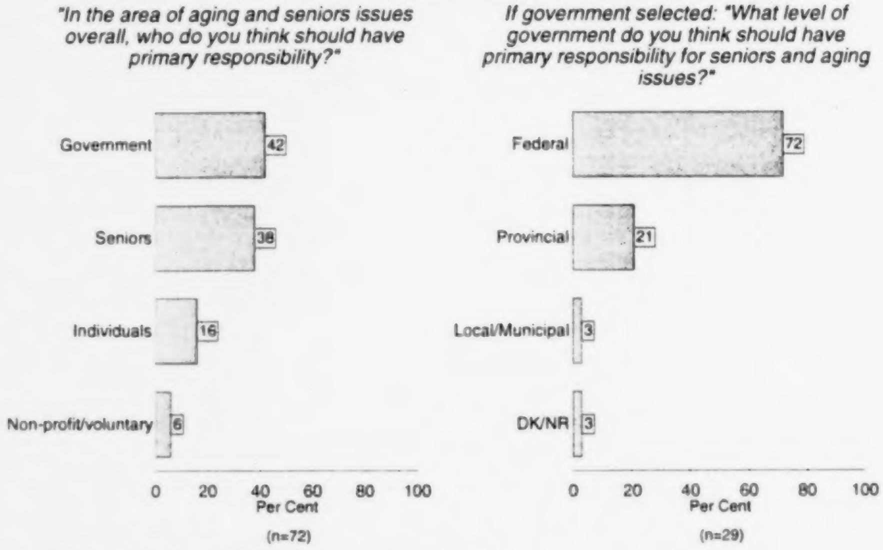
Of those general public clients who selected government as having the primary responsibility for aging and seniors issues, over half (57 per cent) selected the federal government as the level of government which should have primary responsibility. Just under one-third selected the provincial/territorial government and a minority — seven per cent — chose local or municipal government.

The majority of intended beneficiaries (63 per cent) believe that in the area of aging and seniors issues, the federal government should maintain its current level of support. Thirty-three per cent of respondents would prefer that the federal government increase its level of support for seniors issues. A small minority — two per cent — believe the federal government should reduce its support. Respondents also showed concern about current supports available to low income seniors: 59 per cent of respondents believe the federal government should increase its level of support for low income seniors.

The majority of general public clients (56 per cent) also believe that in the area of aging and seniors issues, the federal government should maintain its current level of support. Thirty-eight per cent of respondents would prefer that the federal government increase its level of support for seniors issues. A small minority — two per cent — believe the federal government should reduce its support. Respondents also showed concern about current supports available to low income seniors: 66 per cent of respondents believe the federal government should increase its level of support for low income seniors.

More general public clients aged 65 and over (Exhibit 3.5) would prefer seeing seniors themselves be responsible for seniors issues (38 per cent) than their younger counterparts, but the majority of senior general public clients would give primary responsibility to the federal government (72 percent of those who selected "government"). The majority of general public clients that are seniors also believe that in the area of aging and seniors issues, the federal government should maintain its current level of support (67 per cent). Twenty-nine per cent of respondents prefer that the federal government increase its level of support for seniors issues. Only four per cent believe the federal government should reduce its support. Fifty-six per cent of respondents also believe the federal government should increase its level of support for low income seniors.

EXHIBIT 3.5
Responsibility for Aging and Seniors Issues: Views of General Public Clients (seniors only)



"In the area of aging and seniors issues overall, who do you think should have primary responsibility?"

If government selected: "What level of government do you think should have primary responsibility for seniors and aging issues?"

Source: DAS/S Evaluation, Survey of General Public Clients (seniors only), 1996.

Finally, according to results from *Rethinking Government*, most respondents from the general Canadian population feel that government should increase its support for seniors. Respondents were asked to indicate whether they felt the federal government should increase, maintain, reduce or eliminate its level of support in the area of aging and seniors issues. According to this study, 55 per cent of all respondents feel that government should increase it support and 41 per cent felt that it should maintain it. Very few respondents (four per cent) said that support should be reduced or eliminated. Thus, all in all, significantly more respondents from the general population felt that government should increase its level of support for aging and seniors issues than respondents in the survey of intended beneficiaries (33 per cent) and the survey of general public clients (38 per cent) conducted for this evaluation study.

Some differences among sub-groups of respondents of the *Rethinking Government* survey should also be noted; more respondents from the Atlantic felt that the federal government should increase its level of support (63 per cent versus 46 to 57 per cent). Significant differences were also found between age groups; respondents in the oldest age category (65+) were more likely to indicate that the government should maintain (53 per cent) than increase (44 per cent) its level of support, while respondents in the younger categories were more likely to indicate that the government should increase its level of support (16-29 years olds: 60 per cent; 30-44 years olds: 56 per cent; and 54 per cent for those aged between 45 and 64 years old). Endorsement of increased support was also weaker among higher educated individuals: 51 per cent of those with a university education supported an increase compared to 54 per cent of those with a college education and 59 per cent for those with a high school education or less. A higher proportion of women (61 per cent) also felt that the federal government should increase its support (versus 48 per cent for men).

Thus, most respondents feel that the federal government has a role in the area of aging and seniors. This feeling was qualified by a non-funded expert who stressed that, due to the many factors involved in health, well-being and independence (e.g., income, housing, transportation), this role is not limited to Health Canada. Most agree that seniors have health and social needs — as indicated earlier, available literature supports this — and that the federal government has a coordinating role to play between the different federal and provincial/territorial departments, as well as an information gathering and dissemination role in addressing these needs, mainly because there is no other authority that could ensure these activities across the provinces/territories. A federal division of seniors that gathered and disseminated information on aging and seniors could offer economies of scale that benefit all provinces and territories. Most also agree that the federal government should also support prevention activities, and a few respondents noted that provinces have cut back on preventive measures. Views, however, vary from one group to another as to which roles and actions are most relevant. As indicated, some Health Canada officials (especially in the regional offices of the less privileged regions) would prefer more activities that benefit seniors directly, while others (especially at Headquarters) think that more emphasis should be put on research and information related activities.

Generally speaking, expert panellists are in agreement with other study respondents regarding the appropriate roles for Health Canada. The roles suggested by experts were as follows:

- developing policy and guidelines; policy should be undertaken in the broadest possible extent so it can be implemented by other public jurisdictions, by organizations and by the private sector — the importance of horizontal policy action and vertical policy delivery was stressed by one expert who stated that the federal role should be not only to carry out responsibilities within its jurisdiction, but to also ensure individuals have access to public services offered by other levels of government;
- developing national standards/definitions for programs, ethical research and practice, measures, data elements and training relative to services;
- research (e.g., tracking emerging needs) — including the dissemination of findings;
- coordination and networking;
- funding; funding programs only under specific circumstances (e.g., responding to emergent needs) (a funded expert);

- ☐ dissemination of information on successful programs/projects across regions; and
- ☐ consultation based on extant databases and expertise.

(c) Relevance of At Risk Prioritization

Although the Seniors Independence Program has always given priority to seniors most in need since its inception in 1988, the prioritization of "at risk" seniors in the New Horizons (1993-1995) and the New Horizons: Partners in Aging programs is fairly recent (from 1995 on). This change of orientation had important implications, according to interview respondents.

According to Health Canada personnel and some respondents from NACA, this change was relevant, especially in a context of financial constraints: budget cuts necessitated a tighter selection of projects and in this sense, the targeting of "at risk" seniors made sense. Some provincial/territorial authorities and stakeholders found this orientation to be too short sighted: in reality, addressing the needs of seniors "at risk" means that there are fewer preventive measures for healthy seniors. As indicated earlier, evidence from the literature shows that prevention measures such as physical activity are linked to the prevention of several chronic illnesses. Some respondents argued, however, that the at risk targeting is too restricted and that prevention measures should target all seniors because all seniors are basically at risk. For many, projects should have a preventive orientation that reaches more seniors in order to prevent future problems. One expert panel member indicated that prevention activities are important and should be a main focus for DAS/S. This opinion was shared by another expert who disagreed with the current trend towards assisting only those who are already in trouble.

One provincial/territorial respondent mentioned that there is a continuum between the situation of healthy seniors and those that experience serious health problems. According to this respondent, those at risk already experience some kind of difficulty (e.g., limited income, living alone) and measures are needed to prevent serious health problems. In this sense, the "at risk" requirement is relevant and does not interfere with the "curative" mission of the provinces/territories, especially if the measures are carried out in partnership.

According to some observers, however, the "at risk" requirement only makes funding applications more difficult to fill out. This was especially true in 1993 for New Horizons applicants because, in the beginning, there was no clear definition of who was considered to be at risk. Many observers noted that the relevance of this change should be analyzed for its implications for seniors associations: according to many, the targeting of "at risk" seniors meant that more "sophisticated" applicants got funding.

For some, this means that seniors and grassroots senior organizations are less involved in funded projects than they were previously. In this sense, they do not approve of the "at risk" requirement. Other respondents, however, feel that the involvement of "younger" professionals who are affiliated with these more "sophisticated" applications — gerontological or health professionals, in most cases — gives the projects more depth. It also "mixes" generations and this is seen as positive. Others, however, report cases where seniors only had a "token" participation in the project and their role was mainly to obtain funding. For these observers, the relevance of the "at risk" requirement should be questioned because of these side-effects of the change.

3.3 Areas of Duplication or Overlap

Provincial and territorial governments carry some responsibility for delivering programs and services to seniors based on the division of power between the federal and provincial/territorial governments. This division was initially established in the *British North America Act (BNA Act)* of 1867 (Department of Justice Canada, 1982). With the *BNA Act*, provincial/territorial governments became responsible for issues which are considered to be of a local nature, including education, social welfare, health, and property; the federal government, on the other hand, is responsible for defense, foreign affairs, and other areas not specifically assigned to the provinces/territories, and has primary taxation powers to raise money (Beatty, 1988; Ip, 1991; Lightman and Irving, 1991). Hence, the delivery of health services is a provincial/territorial responsibility. Considering this and the current budget constraints, program duplication appears as a crucial evaluation issue.

(a) Provincial/Territorial Roles and Responsibilities

Health services basically are a provincial/territorial responsibility. Provinces/territories are, however, required to administer their health programs according to the principles and conditions of the *Canada Health Act* which stipulates that the federal government cost-share medical fees with the provinces/territories (National Advisory Council on Aging, 1991a). These principles are:

- ☐ comprehensive coverage of insured services;
- ☐ universality;
- ☐ interprovincial portability;
- ☐ public administration; and
- ☐ accessibility.

If provinces/territories do not adhere to these principles (e.g., extra-billing) and other conditions of the Act, then federal funding could be reduced. The provincial/territorial/federal relations in this domain, however, are in evolution and it is widely believed that the recently established Canada Health and Social Transfer (CHST) will provide more autonomy to the provinces/territories for the allocation of health resources.

In addition to health services, the provincial/territorial governments have legislative jurisdiction to establish other programs such as income security and housing (National Advisory Council on Aging, 1991a). Although they have this legislative jurisdiction, only six provinces and the two territories have used this prerogative to establish income security programs for seniors and six provinces have implemented housing allowance programs for seniors. Seniors receive health services delivered by their province/territory; but not all territories/provinces have specific governmental structures addressing seniors issues specifically. As indicated in Table 3.7, five provinces (Nova Scotia, New Brunswick, Manitoba, Alberta and British Columbia) currently have offices or directorates responsible for seniors and five provinces/territories (Nova Scotia, Quebec, Manitoba, Northwest Territories and British Columbia) currently have a senior advisory body for government.

TABLE 3.7
Provincial/Territorial Structures Addressing Seniors Issues[1]

	New-foundland	Nova Scotia	PEI	New Brunswick	Quebec	Ontario	Manitoba	NWT	Saskatchewan	Alberta	British Columbia	Yukon
Office or directorate responsible for seniors		✓		✓			✓			✓	✓	
Advisory body		✓			✓		✓	✓			✓	
Support for research initiatives on seniors	✓				✓		✓			✓	✓	

1. As of November 1996.

Note: In Newfoundland, Prince Edward Island, Northwest Territories and Yukon, seniors issues are addressed by the Health Ministry. The Minister of Social Services holds responsibility in Saskatchewan. In Quebec, seniors issues are under the responsibility of the Ministry of Citizens and Citizenship. In Ontario, the responsibility is shared between the Health Minister and a Minister without portfolio.

(b) Areas of Duplication: Interview Results

The preceding section suggests that there are potential overlaps between the DAS/S and some provincial/territorial structures. Many interview respondents acknowledged that there are some overlaps in some regions, but this is not necessarily considered by them to be negative. The vast majority of respondents, however, find that DAS/S activities tend to complement those undertaken by the provinces/territories.

Many respondents from the provinces/territories mentioned that there are occasional duplications with some provincial/territorial funding programs which have similar evaluation and funding criteria for community projects. Respondents from Health Canada (HC), however, noted that formal mechanisms around federal/provincial/territorial cooperation have been put into place to facilitate coordination and information sharing (e.g., working committees and committees of seniors officials) and to allow for significant provincial/territorial involvement in the review of projects in the selection process. Most provincial/territorial respondents, however, find that the relations between the provincial/territorial authorities are "distant" and that there are sometimes overlaps because of communication gaps between federal and provincial/territorial authorities at the regional level.

As noted earlier, respondents from the Interdepartmental Committee on Seniors Issues mostly agreed that provinces/territories and communities are closer to seniors. There is concern that direct service delivery may be an unwanted intrusion into provincial/territorial jurisdiction and has the potential for overlap with existing local activities. Respondents from NACA acknowledged that there existed the potential for overlap between the work of NACA and similar provincial councils. All felt however, that NACA and the provincial committees which were established to advise provincial governments on seniors' issues mainly complemented each other.

Funding recipients were asked if their project overlapped with the activities of other federal or provincial/territorial departments or non-government organizations. No respondent thought there were overlaps, but it should be mentioned that many non-government respondents, especially the seniors, openly admitted that they are not knowledgeable enough about government programs to discuss duplications and other issues surrounding DAS/S activities outside those in which they are/were directly involved. Many respondents mentioned that the partnerships established through their project allowed for complementarity between projects and, in fact, helped to avoid overlap in service delivery. A few recipients also believed that their project supplemented activities being carried out by other agencies.

The survey of intended beneficiaries provides another indicator of possible overlaps between DAS/S funded activities and other services and activities in their community. The results indicate that 73 per cent of respondents did not know of any other programs or projects in the community that offered similar activities/services to those under the DAS/S project in which they were involved. Of those who were aware of other similar programs/services (i.e., 24 per cent), less than half actually participated in them (47 per cent) or 11 per cent of the total sample.

Respondents from the expert panel feel that there are no significant duplications, if any. More coordination and collaboration within the federal government and across jurisdictions and organizations was felt to be desirable. One expert indicated that if there is any duplication, it would be a false argument for getting rid of programs because there is so little done for what is needed.

It should also be noted that, according to respondents, initiatives/ programs aimed at seniors within the provinces/territories vary widely. Some provinces/territories have an office or directorate for seniors and others (especially the larger ones) fund community projects and/or research projects similar to those funded by DAS/S. On the other hand, there are some provinces/territories that have very little in terms of programming for seniors. There does not appear, however, to be anything as extensive as the DAS/S (with all its functions and activities) operating at a provincial/territorial level.

The literature review undertaken for this evaluation study does not provide sufficient information on experiences from other countries to truly compare the division of responsibilities on health issues in Canada with other experiences. Literature suggests that there is a trend towards self-help and community-based care (e.g. Sweden, Norway, France and Denmark), but it is difficult to compare the efficiency of these experiences and the framework that supports them with those of other countries. Social philosophies and political organization vary from one country to another (Aging and Senior's Policy Review, January 1994) and what might work in one country might not work in another. Also, additional factors which may affect adaptability of another country's programs are differences in the cost of living and the existence of other benefits (e.g., food stamps, subsidized housing) which may not be known (Baker, 1988).

CHAPTER

4 PROGRAM ACCOMPLISHMENTS

This chapter addresses the many different elements which contribute to a determination of program accomplishments, including program delivery and coordination, partnerships, achievement of objectives, intended and unintended impacts, as well as the strengths and weaknesses of the program.

4.1 Program Delivery and Coordination

(a) Program Delivery

Program delivery comprises a variety of activities related to procedures and systems that deliver products and services to a full range of clients of the program. In this evaluation, the interviews and the survey of general public clients present evidence related to questions about program delivery.

The survey of general public clients included individuals who have requested (via phone, facsimile or other media) specialized advice, information, materials or referrals from the Division. This population includes both seniors and non-seniors. Some of the respondents contacted for this survey were on the DAS/S and/or NACA mailing lists. During the survey, these people were asked, among other things, about how they heard about Health Canada's programs for aging and seniors, the reasons why they contacted the Department, the way they received the information requested, and their satisfaction with the services they received.

Awareness and Reason for Contacting the Division

Results from the survey indicate that general public clients learned about DAS/S from a variety of sources: 27 per cent of respondents heard about Health Canada's programs through a publication; 20 per cent from a health or social service professional; 12 per cent through a seniors' organization or association; 14 per cent from a flyer/brochure/advertisement; 6 per cent from word of mouth; and 16 per cent from another source (and another 5 per cent of respondents could not recall).

For those who contacted Health Canada with an enquiry, DAS/S is perceived as a general information source on government services for seniors: 37 per cent of clients contacted DAS/S in order to obtain information about other government programs. Twenty-five per cent contacted the program to request a publication or research on seniors issues, while 16 per cent of clients contacted the program to obtain information about a specific issue. Another nine per cent wanted information about receiving or applying for funding.

Social support services was the most frequently mentioned subject of clients' contact with DAS/S; 37 per cent of those who made an enquiry for information, advice or referral on this subject. Thirty one per cent of respondents with an enquiry contacted DAS/S for information on financial issues such as pensions.

Results and Satisfaction Levels

Results show that 90 per cent of clients who had made an enquiry obtained the information they were looking for: 72 per cent received information in the mail, 26 per cent received information on the phone and only 10 per cent were referred to another organization[28]. These results are particularly positive if one considers that 37 per cent of enquiries were for information about other government departments' programs.

Accordingly, satisfaction levels are relatively high; 80 per cent of all general public clients reported that their contact with Health Canada's seniors and aging program(s) had met their expectations. Non-seniors were more likely than seniors to say their contact with the program had met their expectations (85 per cent compared to 67 per cent), and mailing list clients were more likely than enquiry clients to say that their contact with the program had met their expectations (85 per cent compared to 72 per cent).

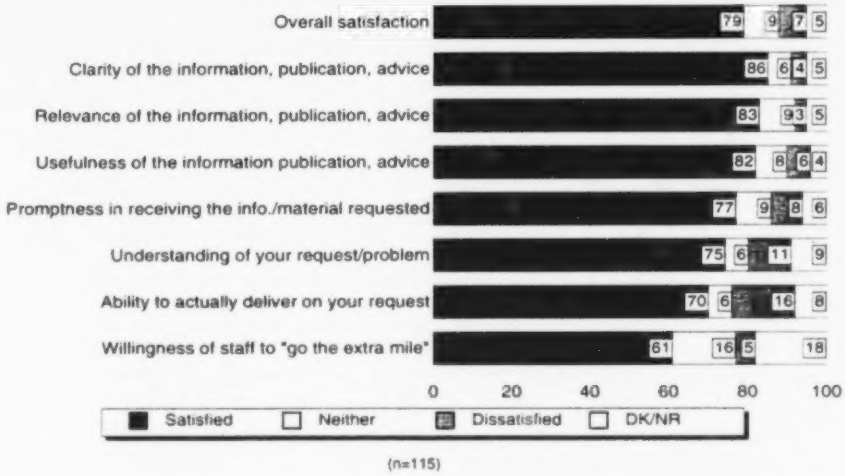
The survey of general public clients asked respondents to rate their level of satisfaction along a number of different dimensions. Overall, clients were satisfied with the information and service they received from Health Canada's seniors and aging programs (79 per cent) (see Exhibit 4.1). Over 80 per cent of clients were satisfied with the clarity, relevance and usefulness of the information, publication or advice they received from Health Canada. A second tier of items refers to the service received from the program. These items received a somewhat lower satisfaction rating. Between 70 and 77 per cent of general public clients were satisfied with the program's promptness, understanding of their request and ability to deliver on their request.

[28] Some respondents received information from multiple sources, which is why these percentages add up to more than 100.

About 60 per cent of clients were satisfied with the willingness of staff to "go the extra mile"[29].

EXHIBIT 4.1
Satisfaction: Views of General Public Clients

"How would you rate the information and service you received from Health Canada's seniors and aging programs?"



Source: DAS/S Evaluation, Survey of General Public Clients, 1996.

Finally, the issue of alternative sources of information or advice was examined in the survey. Sixty per cent of respondents did not believe there were alternative sources of information and 18 per cent did not know. Twenty-three per cent of respondents believed they could have received the same information or advice from a group or agency other than DAS/S. Of those who stated that there were alternative sources for the information or advice they required, 77 per cent had received information from these groups or agencies. Nineteen per cent believed that they could have received better service from these alternative groups or agencies.

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29. It should be noted that, for this question, 18 per cent of respondents stated they did not know.

Administrative Procedures

The successful funding applicants interviewed for this evaluation were asked to discuss the administrative procedures involved in the funding application process, as well as to offer opinions about the level and duration of funding. Non-funded applicants also had views regarding the application and approval process.

Regarding the application for funding process, most applicants said they were familiar with the objectives of the program to which they applied. Many funded and non-funded applicants found the time available to complete the applications forms very short. Apparently, many learn from various sources (e.g., Health Canada, health professionals) that funding would be available for certain types of projects. The problem is that most get this "call for tender" information only a few weeks before the deadline — especially those that learn about it from intermediaries such as a gerontology professional. Some non-funded applicants were refused funding because they submitted their applications a few days late. Most — but not all — non-funded applicants received an explanation as to why their project was turned down. One did not get any feedback at all. In many cases, their application was turned down because their project did not meet the requirements (e.g., at risk) or because there was not enough money to fund their type of project.

Almost half of the funded applicants interviewed commented that the process of obtaining funding was extremely slow; respondents mentioned having to wait what they considered to be extremely long periods of time before hearing whether their project had been funded. These delays may be caused by the multiple actors from Health Canada involved in the process, within and outside the Division. Once having heard they were successful, funded applicants were also left with very short time lines in order to get their projects started. One respondent explained that NGOs need time to recruit volunteers and get the project going; NGOs indicated that they have many constraints that makes it very difficult for them to meet the multiple timing requirements imposed upon them.

The majority of funding recipients found that the other administrative procedures and requirements were considered reasonable. Many successful applicants were very pleased with the support they received from both the regional Health Canada staff as well as the staff at the national office. Relations were described as generally good and staff is considered as being very knowledgeable and helpful.

Level of Funding and Duration

Most funding recipients are satisfied with the level of funding that they received. Recognizing that the Department is undergoing budget cuts, respondents believe that the level of funding is reasonable. Only one respondent commented that the level of funding was insufficient. Some respondents from larger NGOs would prefer funding for longer periods of time: funding over three years, for example, would permit them to plan ahead a bit more. According to many stakeholders who represented funded organizations, non-profit organizations must plan ahead and funding from public sources is a major factor in their projections.

(b) Coordination Activities

According to the *Department of Health Act* (Bill C-95 passed by Parliament on July 19, 1996a), one of Health Canada's roles is to cooperate with provincial authorities with respect to the coordination of efforts made or proposed for preserving and improving public health. Thus, the Division includes an Office of Consultation, Coordination and Partnership Development to undertake a coordination role, which is consistent with Health Canada's mandate. This office, as well as other DAS/S authorities such as those from the funding programs and the Office of Strategic Policy, supports and stimulates policy consultation and coordination.

According to Marshall, Canada has an "uncoordinated panoply of aging and health policy initiatives at federal, provincial and local levels" (1993: 161). As the author puts it "some intergovernmental coordination has been achieved but the degree of federal-provincial coordination has not been great" (1993: 154). For him, there is also a lack of data and data flow: most provinces do not have the resources for accumulating and exploiting health data. As well, there are many sources of information but systematic comparisons of health services and long-term care data are difficult to make because there are no accepted and uniform definitions of the levels of care across the country.

These comments, however, were published in 1993. Not surprisingly, the situation has evolved since Marshall wrote these lines. In 1994, the Interdepartmental Committee on Seniors Issues was created and work to establish a Framework on Aging was undertaken. The Framework itself was officially approved in June 1996. The creation of the Seniors Directorate and consultations with the provincial/territorial authorities are other efforts aimed at improving coordination between the different levels of government on aging issues. Many respondents indicated that these structures have facilitated exchanges between federal and provincial departments. Most of the Health Canada personnel interviewed feel that the Division has been successful in its coordination efforts and that it has managed to put seniors' issues on the agenda of other federal departments and levels of governments. In addition, respondents said that other federal departments have learned to consult directly with seniors on key issues. As well, the Interdepartmental Committee on Seniors Issues (IDCSI) is viewed as an effective vehicle for information sharing and creating opportunities for collaboration on projects across departments. Most regional staff who were interviewed, however, indicated that there was room for improvement with regards to communication and coordination between Ottawa and the regions.

Some Health Canada regional staff, however, gave mixed views about the extent of coordination. According to them, DAS/S tries to coordinate efforts devoted toward seniors and aging issues within the federal government, but the representatives from other departments are resistant to being coordinated and are not empowered to do much.

Overall, provincial/territorial representatives feel that, while the level of coordination between the federal government and the provinces/territories has been good, there is room for improvement (e.g., more input from the provinces/territories). The importance of this coordination role is recognized by the majority of respondents. In some cases, however, the relations between the regional authorities of both levels of government were viewed as "distant" and more cooperation would be appreciated regarding project funding. According to one respondent, this is a federal role and another respondent questioned who else would do it if the DAS/S did not. One respondent, however, challenges whether or not the federal government has a coordination role as he views the relationship between the two governments as an equal partnership and not as one level of government coordinating the activities of both levels.

4.2 Partnerships

An important aspect of DAS/S is the formation of partnerships with seniors, NGOs, other levels of government, business and labour. Through partnerships, whether they involve financial, material or human resources, the impact of seniors programs on the health, well-being and independence of seniors at risk is expected to be enhanced. In this evaluation, the findings related to partnerships were collected through the interviews and the file review.

(a) File Review Findings

According to the information contained in the files, the New Horizons: Partners in Aging and Ventures programs are the most likely to have developed partnerships:

- ☐ Ventures — 94 per cent (n=18);
- ☐ New Horizons: Partners in Aging — 86 per cent (n=42);
- ☐ DAS internal projects — 70 per cent (n=42);
- ☐ Senior Independence Programs — 54 per cent (n=67);
- ☐ NACA — 48 per cent (n=25);
- ☐ SIRP — 30 per cent (n=30); and
- ☐ New Horizons — 25 per cent of projects involved partnerships (n=129).

According to the sample of files reviewed, almost half of the partnerships of Ventures projects involved seniors' organizations. As well, more than half of the partnerships of the New Horizons: Partners in Aging projects involved seniors organizations and/or local NGOs. Thus, the partnership approach encouraged in 1993 and formally adopted in 1995 seems to have been respected in most cases. Seniors organizations and NGOs are the most often mentioned partners in the files, as well as provincial authorities and health services. Other partners include:

- ☐ researchers from universities;
- ☐ independent researchers;
- ☐ business;
- ☐ municipalities;
- ☐ hospitals;
- ☐ media;
- ☐ churches;
- ☐ police departments; and
- ☐ industry associations.

Most partners were involved either as an advisory body or through the provision of human resources. Some partners also provided in-kind contributions or special services such as training and assessment of equipment; dissemination of materials produced; recruiting seniors; media campaigns; and monitoring of projects.

It should be mentioned that partnership development was not a requirement for the New Horizons[30] and Seniors Independence Program projects. Also, according to information obtained during interviews, the SIRP files do not always state if there were partners involved (or not) in the funded projects.

Interview Findings

According to many interviewees, DAS/S' efforts to work with partners is noticeable, although most agreed that there is still room for improvement. Most respondents felt that DAS/S has been successful at developing partnerships at a number of levels. Indeed, an important criteria for funding projects (both research and community) is the creation of partnerships. Many organizations have been involved as partners in the various initiatives undertaken by the Department, including the provinces/territories, local and national level professional associations and NGOs representing seniors themselves. Regional officials have helped to form boards and committees which involve themselves, seniors and these community partners. Partnerships with the private sector have also begun to take hold in some quarters, although a few respondents indicated that, overall, DAS/S was still not very successful in this area. The general feeling was that the private sector will get involved if they perceive the venture to be a "win-win" proposition.

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[30] At least before 1993. The new orientation adopted at that date introduced the partnership and "at risk" criteria. These requirements were formally adopted in the New Horizons: Partners in Aging program.

According to NACA respondents, a number of formal and informal partnerships were formed between NACA and other organizations and individuals involved in seniors' issues and aging. Perhaps the most important was the role NACA played as an intermediary between the federal government and grassroots seniors' organizations. Some provincial/territorial government representatives said, however, that there were few exchanges between them and the NACA representative from their province/territory. Otherwise, provincial/territorial representatives were divided as to whether networks between seniors and other sectors had been developed through the DAS/S. At least some degree of partnership development was recognized by all provincial/territorial representatives. Partnerships have been noted between the federal government and provincial/territorial governments as well as with non-government organizations. A few respondents also noted that partnerships were, to an extent, forced onto funding applicants, as partnership development is a requirement of the New Horizons: Partners in Aging program.

Most stakeholders felt that DAS/S provides opportunities for many parties to work in partnership. These partnerships involve NGOs, different levels of government and people involved in research and were said to result from project funding and events such as seminars. Many, however, say that partnerships with the private sector have been difficult to form.

According to some stakeholders, partnerships between DAS/S and seniors' organizations are also problematic in some cases. For one respondent, collaborations between the DAS/S and seniors' organizations are not true partnerships because they are not true partners: DAS/S sets the rules. According to another interviewee, the provincial seniors' associations generally do not have contact with the DAS/S. While the national seniors' associations have links to DAS/S through events like "Connections '95", the provincial seniors' associations do not participate in these events. Almost all successful applicants mentioned that partnerships were established as part of the project funded by DAS/S. Examples include partnerships with private firms, local community health centre, colleges, hospitals, municipal counsellor and community centres.

4.3 Achievement of Objectives and Intended Impacts

This section assesses the extent to which DAS/S achieved its objectives and intended impacts. We begin by highlighting the main findings.

- ☐ Overall, DAS/S has improved the health, well-being and independence of seniors, through both research and community funding programs.
- ☐ Most experts agreed that DAS/S had made significant progress in meeting all of its short-term goals. They also felt that DAS/S was working constructively towards achieving its long-term objectives. Concerning these objectives, one expert felt that the elimination of barriers to participation did not seem to have the same priority as the other two objectives.
- ☐ Through NH:PA, DAS/S community funding programs have become more successful at targeting at risk seniors. According to the survey, NH:PA intended beneficiaries were more likely to be at risk financially compared to those of other programs. They were also somewhat more likely to be socially isolated. Both these factors are crucial determinants of health. As targeting at risk seniors is a requirement of NH:PA projects, this finding is not all that surprising.
- ☐ Community funding program impacts have mainly been in the form of improving beneficiaries' mental well being.
- ☐ Leveraging and partnerships have played an important role in community funding projects and have led to a number of projects to either become self-sufficient or consider self-sufficiency as an option.
- ☐ A significant proportion of surveyed intended beneficiaries (23 per cent) said that the service they received from a community funding program had no impact. Even though NH:PA intended beneficiaries were at

greater risk, due mainly to their financial situation, impacts were not more apparent for this group. This may be due to the fact that the services delivered by NH:PA projects generate mainly mental health impacts as opposed to financial impacts.

- ❑ There is some conflicting evidence concerning the impact of DAS/S' "internal" activities on policy coordination and promotion of policy, but with a preponderance indicating that DAS did have a significant positive impact in this area. DAS support of NACA activities was very significant and positive.
- ❑ DAS/S research programs (i.e., SIRP and NACA) have produced valuable results, which in turn, have been transformed into widely disseminated information. This information has been mainly used by Canadian policy makers, researchers and seniors groups.
- ❑ SIRP research projects have been innovative, and both SIRP and NACA projects have fostered important and unique (e.g., multidisciplinary) collaboration and partnerships.
- ❑ Overall, the activities of SIRP and NACA have had an impact on policy and in advancing the state of knowledge about aging and seniors issues. The extent of NACA's direct impact on the formulation of policy, however, is less certain.
- ❑ While SIRP and NACA were not intended to produce impacts at the individual level, (e.g., helping seniors make decisions), many of those who were interviewed indicated that some of the information produced by NACA, and to a lesser extent SIRP, would be useful to individual seniors.

The detailed findings which are presented in the remainder of this section are organized under three main headings: community funding programs; research activities; and DAS internal activities.

(a) Community Funding Activities

It is appropriate to begin by stating that all of the funding recipients who were interviewed as part of this evaluation said their project had met all stated objectives, or was on track to do so. Other, more detailed findings are presented below.

Targeting

Over the years, community funding programs have targeted both seniors in general and seniors at risk. Seniors "in need" have been a target of SIP since the program's inception in 1988. In 1994-1995, seniors who were at risk became the focus of community funding programs with the creation of NH:PA. It should be noted that priority setting for NHPA is effected in each region, as well as at the national level. As a result, projects are geared to meet or address the situations of risk specific to each region.

Table 4.1, which is based on the findings of the file review, shows the relative emphasis of different programs on targeting seniors in general compared to seniors at risk. It is important to note that a program could target more than one group.

The largest contrast is between the long standing New Horizons program and the recently established NH:PA. A similar pattern is found with respect to program clients.

TABLE 4.1
DAS/S Senior Community Programs Target Groups and Clients[31]

	Percentage of Projects			
	NH (91-95)	SIP (91-95)	Ventures (93-95)	NH:PA (1995)
Target Groups				
Seniors in general	67	51	50	29
Seniors at risk	49	75	80	98
Other Groups	11	11	22	10
n	129	67	18	42
Clients				
Seniors in general	76	55	72	57
Seniors at risk	34	51	69	69
Other groups of seniors	4	10	6	14
Other groups	9	75	49	55
n	129	67	18	42

As revealed below, the socioeconomic and demographic profile of intended beneficiaries who responded to the survey suggests that, between 1991 and 1995, community funding programs generally benefited relatively healthy, active and financially secure seniors. This finding is expected, given the overall targeting mix of programs (i.e., seniors in general and seniors at risk). Characteristics of intended beneficiary respondents include the following:

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[31] The *target group* was identified as those people who were the ultimate beneficiaries of the project, that is, the group whose needs the project was/is attempting to address. Although for all projects seniors or a subgroup of seniors would be targeted, some projects would also target other groups such as youth or caregivers. The *clients* were considered to be those people who would benefit from the project, but were not necessarily the target group. For example, in a project that provides information to professionals within the community to help them better address the needs of the seniors they serve, the professionals would be considered to be the client. In those cases where a project is providing direct services to a target group, the target group would also be considered to be a client.

- ❑ 85 per cent lived in a private residence;
- ❑ 87 per cent had enough income to meet their needs;
- ❑ 56 per cent performed at least "some" volunteer work;
- ❑ 81 per cent indicated spending time helping family, friends and neighbours; and
- ❑ 93 per cent rated their health as "average" or "very good" compared to other people their age.

In light of the recent emphasis placed on seniors at risk in the NH:PA, it is useful to compare the profile of intended beneficiaries of each of the four programs, based on the survey results. This analysis illuminates the extent to which the heavy focus on at risk seniors found in NH:PA guidelines and criteria have materialized in practice. Profiling intended beneficiaries in this manner also allows the accuracy of SIP targeting to be assessed, given this program's consistent emphasis on seniors "in need".

Overall, the profile of NH:PA intended beneficiaries was similar to those of the other programs, particularly New Horizons. The one notable exception was that a significantly higher proportion of NH:PA beneficiaries tended to be poor. They were also somewhat more likely to be socially isolated. Key findings are presented below.[32]

- ❑ The majority of intended beneficiaries of all four programs were active.
- ❑ Most performed volunteer work. Only 36 per cent of NH:PA intended beneficiaries indicated that they were not involved in volunteer work, compared to 36 per cent of New Horizons beneficiaries and 26 per cent and 54 per cent of SIP and Ventures intended beneficiaries.

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[32] The sample sizes are as follows: NH:PA (n=50), NH (n=298), SIP (n=171), Ventures (n=22) and "Other" (n=7). Some caution should be exercised in interpreting the data given some of these small sample sizes, particularly with respect to the Ventures program.

- ❑ Similarly, the vast majority of beneficiaries across all four programs spent time helping out family. NH:PA intended beneficiaries (92 per cent), however, were much more likely to provide help compared to the beneficiaries of other programs, whose level of involvement in this type of activity ranged between 80 per cent for SIP to 82 per cent for New Horizons and Ventures.
- ❑ A higher proportion of NH:PA intended beneficiaries (28 per cent) indicated that they did not have someone in their life they could confide in, compared to beneficiaries of New Horizons (10 per cent), SIP (five per cent) and Ventures (14 per cent).

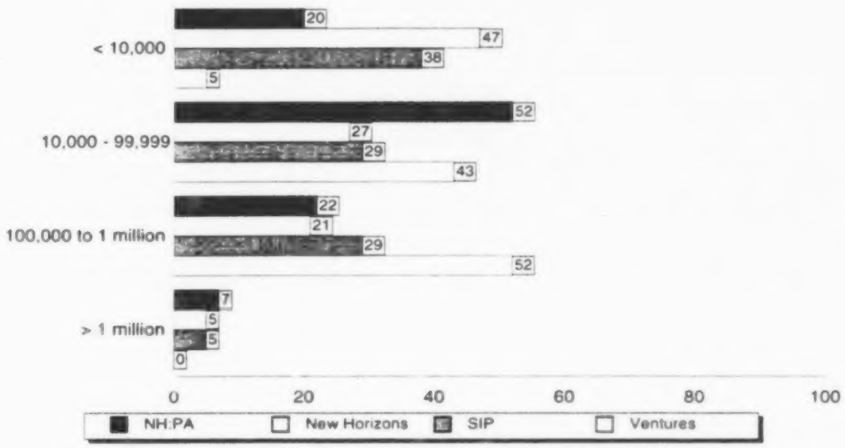
Almost all intended beneficiaries indicated that their health was either very good or average compared to the health of other people they knew. Specifically, only four per cent of NH:PA intended beneficiaries indicated that their health was poor, compared to seven per cent of New Horizons and SIP beneficiaries and five per cent of Ventures beneficiaries.

NH:PA intended beneficiaries were much less likely to live in small communities of less than 10,000 inhabitants compared to intended beneficiaries of New Horizons and SIP. As shown in Exhibit 4.2, NH:PA beneficiaries were more likely to live in communities of between 10,000 and 100,000 inhabitants.

There were significant differences in the socioeconomic status of intended beneficiaries across the four programs.

- ❑ About one-half of NH:PA intended beneficiaries (51 per cent) did not have a high school diploma compared to 44 per cent of New Horizons intended beneficiaries and 32 per cent of SIP and Ventures intended beneficiaries.
- ❑ More importantly, almost one quarter of surveyed NH:PA intended beneficiaries (24 per cent) reported that their total annual income barely met their needs, compared to only 11 per cent of New Horizons, 6 per cent of SIP and 18 per cent of Ventures beneficiaries.

EXHIBIT 4.2
Size of Community of Intended Beneficiaries



(n=2,523)

- Similarly, a much higher proportion of NH:PA intended beneficiaries (32 per cent) indicated that their total annual income was less than $10,000 compared to the beneficiaries of the other three programs. Only nine per cent of New Horizons, seven per cent of SIP and five per cent of Ventures beneficiaries said that their income was less than $10,000.

Taken together, these findings show that the significantly increased focus on at risk seniors vested in NH:PA has, in practise, led to a relatively more economically insecure clientele being served. The success of NH:PA targeting is particularly significant when compared to the targeting, or lack thereof, of SIP. As revealed in the above findings, SIP intended beneficiaries cannot in any way be considered more "in need" or at risk than New Horizons intended beneficiaries, based on the survey findings. In fact, the data suggest that they may have been less in need.

The findings related to NH:PA show that its intended beneficiaries appeared to be "at risk" mainly because of their precarious economic status as opposed to other possibilities examined in the survey and file reviews, such as their overall health status or community size. Given that income inequality is one of the most powerful determinants of health[33], it is very appropriate to determine risk based on economic status. It is important to mention, however, that the limitations of the study design suggest that it would be wrong to preclude the possibility that NH:PA intended beneficiaries were not at risk due to other factors and targeted by a funded project for specifically those other factors.

While the survey and file review findings strongly suggest that program targeting has improved since the creation of NH:PA, especially compared to the SIP program, it must also be emphasized that it is beyond the scope of the program to improve the income status of seniors. As demonstrated later in this chapter, the fact that the program was not designed to address the economic problems of seniors who are financially at risk, may have lessened its impact. The evidence indicates that this may have been caused by the fact that interventions/services were aimed mainly at improving the mental well-being of beneficiaries (e.g., seniors visiting programs, the organization of social gatherings) as opposed to their economic status.

Expert panellists also noted that while Seniors Community Programs Funding projects have been somewhat successful at addressing the needs of seniors at risk, they have not addressed all high priority needs, particularly economic security. One expert went further, stating that social, recreational, participatory and mental benefits were not high enough priority needs to justify public expenditures. This expert continued to note that direct and hard benefits in priority areas were insufficient for the level of public expenditure.

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[33] Evans, R. et al: *"Why Are Some People Healthy and Others Not?"* Walter de Gruyter, Inc., New York, N.Y., 1994.

Improving and Preserving the Health, Well-Being and Independence of Seniors in Canada

The file review indicated that the main focus of community projects was to improve the health, well being or independence of seniors.[34] As shown in Table 4.2 below, this was a particular focus of NH:PA.

In terms of impacts, the majority of surveyed intended beneficiaries said that the services received from DAS/S projects had a positive impact on their health, well being and/or independence (74 per cent). As shown in Exhibit 4.3, impacts were mainly at the level of mental well-being and social interaction (66 per cent). It is important to point out that it might be too soon in the life of the projects for the full impacts on beneficiaries to be felt, especially with respect to physical health outcomes.

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[34] Following are the definitions which were used for the file review:

Health and Well-Being. A project was coded as addressing health and well-being if its activities were aimed at problems such as seniors with chronic illnesses, physical disabilities, mental-illness, socially isolated seniors and seniors' general health. For example, a meals-on-wheels program aimed at preventing seniors from falling into the "tea and toast" spiral by providing seniors with nutritious meals would be coded as addressing health and well-being.

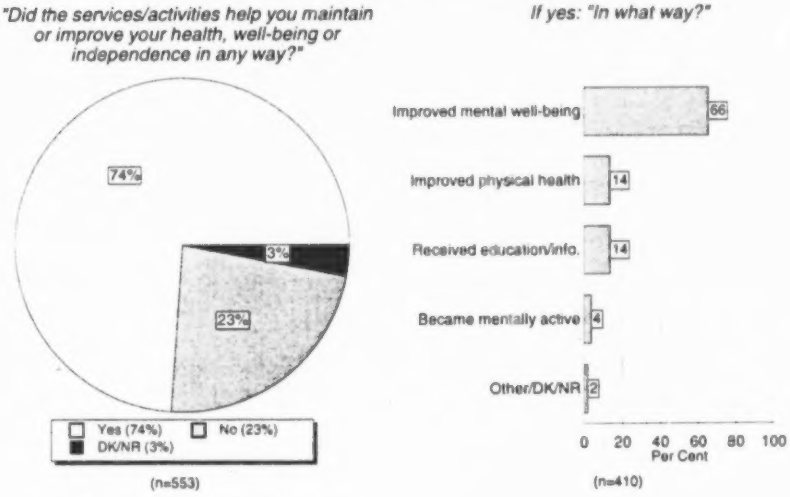
Independence. Defining independence separately from health and well-being was a challenge as the three are so inextricably intertwined. There is not a simple definition of independence as it refers to seniors. It was decided that a project would be coded as addressing independence if its activities were aimed at enabling seniors to remain within the community by, for example, not only having services and activities available but also by having them be accessible (e.g., through transportation). This definition provided analysts with a mere guideline. Additionally, inherent in the word "independence" is "lack of dependency". Consequently, projects whose activities were clearly aimed at reducing a senior's dependency would also have been coded as addressing the issue of independence. For example, a project in which volunteers assisted seniors with their grocery shopping would be considered addressing the issue of independence by not only relieving that senior's dependency on family and friends for their grocery shopping, but by giving them some control over what they buy.

TABLE 4.2
Overview of Addressed Needs by DAS/S Senior Community Programs

	Percentage of Projects			
Addressed Need*	**NH (91-95)**	**SIP (91-95)**	**Ventures (93-95)**	**NH:PA (1995)**
Health and Well-Being	89	71	79	91
Independence	33	26	63	38
Attitudes towards aging	10	16	50	5
Barriers to participation in society	36	24	41	31
Other	16	47	16	5
Total n	129	67	18	42

*Note: A project could address needs in more than one area.

EXHIBIT 4.3
Impact of Services/Activities: Views of Intended Beneficiaries



Source: DAS/S Evaluation, Survey of Intended Beneficiaries, 1996.

The finding that few beneficiaries reported improved physical health may also be explained by the fact that, as revealed by the survey, very few intended beneficiaries were in poor health.

One-quarter of surveyed intended beneficiaries indicated that the services/activities they received did not help them in any way to maintain or improve their health, well-being or independence. The proportion of intended beneficiaries who indicated no impact did not vary significantly across the four program types. A little over one fifth of NH:PA intended beneficiaries (22 per cent) indicated no impact, compared to 26 per cent of New Horizons, 20 per cent of SIP and 23 per cent of Ventures intended beneficiaries. One might expect impacts to be felt more by NH:PA intended beneficiaries given that they were at greater risks, and thus presumably in greater need. However, as noted earlier, NH:PA beneficiaries were ***economically*** vulnerable. That is, they were significantly more likely to have lower incomes and less discretionary income. Given that NH:PA program activities aimed mainly at improving health, well-being and independence, mainly through improved mental well-being, and not improved financial status, this lack of difference in impacts is not surprising.

An analysis of impact according to project start date shows a fairly stable pattern with respect to the percentage of intended beneficiaries indicating that services/activities helped to maintain or improve their health, well-being and independence. Between the years 1991 and 1995, the proportion of respondents indicating an impact fluctuated within a narrow band of 70 to 76 per cent. As shown in Table 4.3, however, there was a significant increase in the percentage who experienced a positive impact in 1996. This same table reveals a generally similar pattern when project end dates are used in the analysis.

TABLE 4.3
Self-Reported Impact by Project Start and End Dates

	1991	1992	1993	1994	1995	1996	1997	TOTAL
Start date	70% n=21	77% n=72	75% n=124	72% n=120	72% n=41	85% n=22	n/a	74% n=400
End date	n/a	71% n=15	72% n=55	81% n=71	69% n=88	72% n=98	86% n=67	75% n=394

Overall, the experts agreed that DAS/S has improved the health, well-being and independence of seniors. Most, but not all, also agreed that this was true for at risk seniors, especially since the reorientation of the funding programs. One expert, on the other hand, felt that the evidence suggested that DAS/S had not targeted those most at risk.

There was some agreement DAS/S filled a unique and necessary role in Canada. The finding that mental well-being was one of the more frequently reported results of various programs was very positive in the eyes of one expert, since there is considerable evidence that good mental health is reflected in a more active lifestyle and frequently in better general health.

It is important to note that a number of the experts cautioned that the amount of evidence that actually substantiated the conclusion that DAS/S was beneficial was rather limited. They pointed to a lack of "sensitive sophisticated measures" from recipients themselves (i.e., a control and treatment group design).

Experts were divided on the question of whether or not DAS/S had been effective at meeting high priority needs. The general view was that DAS/S had been moderately effective, with one expert pointing out that this was difficult to assess given that many DAS/S impacts could only be felt indirectly by intended beneficiaries. Some experts focused on one of the major identified risks, namely economic security. They felt it important that the issue of economic risk be more clearly addressed by DAS/S, especially given the importance of economic security as a determinant of health and because of the emergent needs of the still insufficiently identified vulnerable sub-population of aging Canadians (e.g., the "prematurely retired") as very closely related to this area.

Promoting Collaboration and Innovation

One of the purposes of the file review was to assess the extent of innovation of and collaboration/partnership in funded projects. Table 4.4 presents the results of the review.

Innovation was defined in a number of ways, from introducing new knowledge and issues to synthesizing new knowledge. The results are fairly consistent across the definitions of innovation, with very few New Horizons projects deemed innovative. In contrast, over one half of NH:PA projects introduced a new approach. This finding indicates that the current criteria of innovation is being applied. Interviews with regional Health Canada personnel suggest that because innovation is a requirement of NH:PA the possibility of replication of projects is not high.

The review of project files produced what should be considered a conservative estimate of innovation, because judgement was based solely on whether this information was reported in the files or if it was clear to the reviewer that the project was innovative. Consequently innovation may have been underestimated.

TABLE 4.4
Extent of Innovation and Partnerships by DAS/S Senior Community Programs

	Percentage of Projects			
Type of Innovation	**NH (91-95) n=129**	**SIP (91-95) n=67**	**Ventures (93-95) n=18**	**NH:PA (1995) n=42**
Projects introducing new approach	2	10	11	52
Projects introducing a new issue	2	6	17	5
Projects targeting different groups of seniors	1	6	6	7
Projects occurring in a different milieu	2	18	11	10
Projects bringing together different stakeholders	2	5	17	12
Projects synthesizing new knowledge	1	5	0	7
"Partnerships working in partnership"	25	54	94	86

Expert panellists were also asked to comment on how effective Seniors Community Programs had been at supporting the development of innovative programming. Overall, the expert panellists felt that while there had been some support, there could have been more.

Table 4.4 also reveals the proportion of projects which were most likely to have fostered collaboration. Ventures in Independence and NH:PA were most likely to foster partnership, while conversely, New Horizons projects were least likely to have done so. This is consistent with changing program criteria.

Examples of projects which fostered collaboration were provided by some Health Canada officials who were interviewed. They noted that projects often involved a "train-the-trainer" element which, for a small investment, have had a beneficial impact on many professionals and seniors. In addition, many projects have involved the provision of funding to national and regional networks of organizations. Coalitions have developed around specific issues (e.g., medication use, injury prevention).

Most of the stakeholders who were interviewed felt that many of the community projects that were funded by DAS/S were innovative, either because of what was produced/delivered or due to the way various groups worked together. Some also pointed out that funding requirements ensured that there was some measure of innovation in new projects. It is important to note, however, that some stakeholders, as well as a few Health Canada personnel, felt the innovation criteria is "too restrictive", leading to some "good projects" not being funded.

The experts' comments were informed both by the evaluation evidence and by their personal knowledge of the research and community funding programs. Overall, experts were confident that DAS/S has been successful in developing partnerships throughout its existence. For example, according to one expert's "detailed knowledge of all of the SIRP projects" all of them have involved multiple partnerships. In considering the view of this one expert, it should be noted that the file review did not find evidence to suggest such a high level of partnership.

Some experts, mainly those who were less sure about the success of DAS/S in the area of partnerships, felt that there was still room for improvement, particularly with respect to voluntary and seniors' organizations, as well as with the private sector:

Self-Sufficiency and Leveraging

The review of project files provided the best information on the issues of self-sufficiency and leveraging. Overall, the evidence suggests that both leveraging and self-sufficiency were a significant part of the projects funded by Health Canada community funding projects. Detailed findings are presented below.

New Horizons

The file review revealed that during the application for funding stage, no New Horizons projects indicated that they were planning on obtaining funding from sources other than Health Canada. It should be noted, however, that it was not a requirement of New Horizons projects to seek other funding sources and applicants were not required to provide information on complementary funding sources.

Over time, many New Horizons projects adopted self-sufficiency as a goal. Documents in the files, such as evaluation reports, indicated that the majority had plans to continue their activities once funding ended (71 per cent). This necessitated that sources of funding other than Health Canada be accessed. Identified potential sources of new funding varied greatly and included the following:

- ☐ fund raising activities;
- ☐ municipalities;
- ☐ community agencies;
- ☐ fees;
- ☐ grants;
- ☐ provincial support; and
- ☐ volunteers.

There was very little information on the dollar amount of the funding provided by these other sources after the Health Canada funding expired. Of those projects which indicated that continuance was not a goal of the project (41 per cent), only seven per cent (nine projects) sponsored activities beyond the funding period.

A longitudinal analysis of the files shows that projects were more likely to have self-sufficiency as a goal during the early part of the decade until 1993-94 (i.e., 75 per cent in 1991-1992, 79 per cent in 1992-1993 and 87 per cent in 1993-1994). This trend ended in 1994-95 when the percentage of projects indicating continuance decreased to about half (49 per cent). This decrease may be partly explained by the fact that many projects were ongoing (17 per cent of projects reviewed for that year) and continuance or self-sufficiency had yet to be established as a goal by project funding recipients.

SIP

Of the 64 files which were reviewed, six files indicated that funding was received from other sources (an average contribution of $35,684). Seven files showed that projects involved between seven and many hundreds of volunteers, with most involving fewer than 50 volunteers. This reveals significant leveraging of volunteer effort from community members for these projects.

Most files that were reviewed did not indicate whether or not the project was or intended to be self-sufficient after Health Canada funding ran out. A total of 19 project files (28 per cent) indicated that the project was already or intended to be self-sufficient.

Ventures in Independence

Of the 18 files which were reviewed, four files documented the leveraging of financial contributions from other sources. Contributions varied between $18,320 and $512,225. Nine projects received in-kind contributions. Only one file provided information on volunteer participation (seven volunteers in that project). Of the 14 out of 18 projects that provided the information, seven projects indicated that their activity would be self-sufficient after the funding period.

NH:PA

Self-sufficiency was encouraged for New Horizons: Partners in Aging projects. Due to the fact that a large number of NH:PA projects reviewed were ongoing at the time files were reviewed, it was not possible to comment definitively on the extent to which projects were actually self-sufficient.

Of the nine projects for which information was available, all indicated that they would be self-sufficient after DAS/S funding ran out. Most identified specific sources of future funding, included city councils, sales of publications and seniors and community organizations. There was no information on the dollar amounts or extent of volunteer or in-kind contributions expected from these sources.

The Promotion of a Positive and Realistic Image of Seniors

Many of the Health Canada officials who were interviewed felt that it was perhaps most difficult to demonstrate impacts in this area. Notwithstanding this general view, a few pointed to the fact that community funding programs have helped seniors in some communities to feel less isolated and increased their self-esteem, thus boosting their self-image as seniors. In addition, it was noted that a television program (on a women who became a widow), vignettes and research studies specifying the types of seniors' activities, services they utilize, etc., have all helped to promote a positive and realistic image of seniors.

Provincial/territorial representatives who were interviewed were in agreement that the DAS/S had promoted a positive and realistic image of seniors. Similarly, some of the stakeholders who were interviewed indicated that community projects were successful at achieving this goal. They felt that the direct involvement of seniors in community projects showed both seniors and other generations that older Canadians can be useful and active.

(b) Research Activities

It is always difficult to determine the precise impacts and effects of research activities. In many cases, the more significant outcomes of a research project appear long after the publication of findings, and only as one part of an evolving body of research. For this evaluation, it was nevertheless possible to document the more immediate impacts of research activities, as well as identify further expected impacts.

Targeting of Research Activities

The research activities of DAS/S revolve around SIRP and NACA. Table 4.5 presents an overview of the needs addressed by these two programs based on the review of project files.

TABLE 4.5
Overview of Addressed Needs by DAS/S Research Programs

	Percentage of Projects	
Addressed Need*	**SIRP**	**NACA**
Health and Well-Being	71	52
Independence	23	40
Attitudes towards aging	7	36
Barriers to participation in society	3	20
Other	40	72
Total n	30	25

*Note: A project could address needs in more than one area.

The review revealed that SIRP projects focused mainly on health and well-being (71 per cent), while NACA research was more evenly spread among potential categories of need.[35]

Table 4.6 presents the results of the review of SIRP and NACA files with respect to target groups (i.e., the ultimate beneficiary of a project) and client (i.e., the immediate beneficiary of a project).

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[35] The "Other" category for SIRP projects includes needs such as the need to develop acceptable and workable policies tailored to the social, political and economic environment of the 1990s; the need for information on broad use of medication by seniors; the need to translate research findings into practice; and the need to accurately capture the cost of informal care. NACA projects assigned to this category usually addressed more than one need. That is, one of the four standard needs identified in the table plus one or more specific information needs identified on an *ad hoc* basis.

TABLE 4.6
DAS/S Research Programs Target Groups and Clients

	Percentage of Projects	
	SIRP	**NACA**
Target groups		
Seniors in general	43	92
Seniors at risk	63	8
Other groups	17	80
n	30	25
Clients		
Seniors in general	20	72
Seniors at risk	17	4
Other groups of seniors	13	52
Other groups	93	100
n	30	25

The most noteworthy finding is the emphasis given by NACA projects to seniors in general, compared to SIRP projects which tended to target seniors at risk. It is also interesting to note that both NACA and SIRP projects had researchers and research organizations as their main client group (i.e., those who benefit from the project but are not the ultimate target group). Grouped under the "Other" category, these clients included independent researchers, universities, centres of gerontology and provinces and territories.

Promoting Collaboration and Innovation

The evidence suggests that one of the strong points of the SIRP program was the degree of innovation in its projects. The extent to which innovation can be ascribed to NACA is somewhat less certain due to the more limited available evidence on innovation. The vast majority of NACA files, which were reviewed as part of this evaluation, did not contain information on whether a project was innovative. The files did reveal, however, that NACA projects were more likely to promote collaboration.

A high proportion (77 per cent) of the SIRP project files which were reviewed clearly indicated innovation, with 20 per cent of these indicating innovation in more than one respect. SIRP projects were most likely to be innovative by synthesizing new knowledge. Health Canada officials agreed that SIRP research projects have been innovative, particularly in the fields of medication use and Alzheimer's research.

With respect to collaboration, about one-half of NACA projects (48 per cent) and one-third of SIRP projects were considered likely to have fostered collaborations. The key informants who were interviewed as part of this evaluation provided some specific examples of collaboration. Most significantly, Health Canada officials indicated that a network of researchers with an interest in seniors' research has been established which otherwise would never have formed without SIRP funding. Moreover, this network has led to the formation of new, productive and multidisciplinary partnerships, as well as the implementation of alternative approaches to research.

This view was generally corroborated by the provincial/territorial representatives who were interviewed. The majority said they were aware of networks of researchers and identified SIRP as the likely primary source of these networks.

Providing the Information Seniors Need to Make Informed Choices

For DAS/S, NACA publications are a primary method of providing information to help seniors make informed decisions. According to Health Canada officials and NACA members, publications have been written to advise seniors on a number of issues, including preparing for retirement and stay-at-home care. Quite a few of those who were interviewed felt that these publications have had a significant impact in terms of providing useful and timely information to seniors, but all agreed that the publications certainly had the potential for helping a greater number of individual seniors make more informed choices.

In a different vein, the NACA members who were interviewed noted that the Public Forum on Seniors and Medication, broadcast in January 1995, brought together a number of experts and stakeholders in a fairly high profile discussion of issues surrounding seniors and medication. There was agreement that this forum, which was sponsored by NACA, had a significant impact on both seniors and health professionals.

There was consensus among those who expressed an opinion on NACA and SIRP projects that these produced quality research and that the resulting dissemination of publications, reports, position papers, etc. has reached researchers, governments and stakeholders. Questions were raised by some Health Canada officials about the extent to which information "filtered down" to individuals. This concern was echoed by the provincial/territorial representatives, stakeholders and the non-funded applicants who were interviewed. All agreed, however, that it was not possible to comment with great certainty on how much information actually gets into the hands of individual seniors. There was also some agreement that ethnic seniors, seniors who are illiterate and those who live in rural areas were particularly difficult to reach.

The survey of general public clients, which included recipients of NACA information, supports the finding that NACA provided information needed by seniors to make informed choices. A plurality of surveyed seniors indicated that their contact with DAS/S provided them with information, advice on a referral with ultimately allowed them to take action to improve their health, well being and independence.

It is very important to note that these findings should not be interpreted as criticism of the programs, since neither SIRP nor NACA were intended to disseminate information to individual seniors. Rather, the views expressed by Health Canada officials and others, suggest that there is potential for bringing direct benefits to individual seniors by developing a more systematic dissemination strategy aimed at individuals, particularly with respect to NACA publications.

Increasing and Disseminating Knowledge and Resources

The review of SIRP project files led to the identification of a number of specific intended impacts and effects, most of which were related to increasing and disseminating knowledge and resources. They included the following:

- ☐ better linkages between research and policy;
- ☐ more effective care of patients;
- ☐ better evaluation of new treatments;
- ☐ better targeting of health promotion activities;
- ☐ empowerment of seniors;
- ☐ better testing methods of diseases; and

- preventative measures for cognitive impairment of the population as a whole.

The most frequent outputs of SIRP projects were research reports (48 per cent) and publications and workshops (22 per cent) (e.g., Proceedings of the Symposium on Methodological Diversity and Quality in Applied Social and Health Research on Aging and Seniors' Issues, 1994). Similarly, the main output of NACA projects was publications (e.g., the *Writings in Gerontology* series). Advice to the Minister was an explicit output in only 16 per cent of reviewed NACA projects. This finding is noteworthy given that NACA's main objective is to advise the Minister.

NACA files did not contain much information on impacts and effects, with the notable exception of the development of a discussion paper on aging and a successful public education campaign on the problem of seniors and medication which was considered successful by interviewees.

Like those of SIRP, the activities of NACA projects were mostly related to increasing awareness and disseminating information. Of the 25 files which were reviewed, 68 per cent had a communications activity, the same proportion of files involved increasing awareness of seniors issues and almost half (44 per cent) involved dissemination of information. According to the NACA members who were interviewed, as well as others, NACA publications have been used by various types of seniors' groups across the country, MPs and provincial governments. Some groups used the publications to educate seniors in their communities about key issues. Other groups used the information to make presentations to various levels of government.

According to Health Canada personnel, SIRP and NACA have commissioned research and disseminated findings on a wide variety of topics, including palliative care, caregiver issues and elder abuse. Dissemination has taken the form of successful print media, workshops and other types of meetings with the policy and research communities (through SIRP) and to some seniors themselves (through NACA). The SIRP Advisory Committee was specifically identified as having made a valuable contribution to information consolidation and sharing by bringing different researchers and stakeholders together. One of the stakeholders who was interviewed indicated that some studies would not have been undertaken without support from SIRP.

Almost everyone who was interviewed agreed that one of the main achievements of NACA lay in the quality and popularity of the publications they produced. The publications were said to not only have made a contribution to advancing the state of knowledge and research (e.g., gerontology), but perhaps more impressively, also attracted a great deal of attention from seniors organizations. According to NACA members, the feedback received by NACA about their publications was overwhelmingly positive.

The stakeholders who were interviewed generally agreed that DAS/S has been successful at increasing and consolidating knowledge through the work of SIRP and especially NACA. The latter's publications were described as "useful", "excellent", "non-partisan and unbiased" and "up-to-date".

The four SIRP funding recipients who were interviewed provided a valuable overall indication of the extent to which projects met their objectives. In all cases, recipients said their project had either met all objectives, or was on track to do so.

Identifying and Addressing the Priority Needs of Seniors

The review of NACA files showed that the goals and objectives of projects related mainly to addressing information needs — gaps which were identified either internally, through a review of literature or statistical reports, or in response to a Ministerial request.

A number of Health Canada officials and NACA members explained that NACA served as a lynch-pin between the federal government and seniors' groups. The Council's expertise, objectivity and close proximity to the Minister earned them credibility from disparate and sometimes vociferous senior's advocacy groups. From the government's perspective, NACA serves as an efficient and articulate source of expression for the needs and concerns of Canadian seniors, while also explaining the government's positions to seniors.

One stakeholder indicated that NACA's work had an impact on the strategies selected by his organization to meet the needs of seniors.

For its part, the SIRP Advisory Committee has played an important role in focusing research efforts on addressing the most pressing needs of seniors, according to Health Canada officials.

The Development and Promotion of Integrated Policies and Strategies

According to Health Canada officials, SIRP has been very successful at helping to bridge the gap between research and policy by allowing researchers and policy makers from different parts of the country to work together.

A number of Health Canada officials felt that NACA publications have been instrumental in sensitizing professionals to the particular needs and concerns of seniors through position papers and sundry publications, thereby putting seniors' issues, such as caregiver mental health and elder abuse, "on the map". Sharing this information with the public, professionals, researchers, policy designers and seniors themselves has led to greater coherence in approaches.

The amount of success that NACA has had in terms of more direct influence over policy is less clear. The main objective of NACA is to provide advice to the federal government, particularly the Minister of Health, on seniors issues and aging. If this objective is assessed in terms of "influence" over government policy, collectively those who were interviewed felt that NACA had, at best, moderate success, given interviewees' inability to link evolution in government policy to the output of NACA or the advice of its members. Many were also quick to add that it was very difficult to gauge the influence that NACA had on the government.

NACA members who were interviewed expressed confidence that the Minister of Health had the opportunity to know the views of NACA through the position papers and other documents which were produced by the Council and systematically forwarded to the Minister's office and by the briefings which the Minister received from time to time from the Chair of NACA. Some felt, therefore, that the cumulative impact on the federal government of the information which emanated from NACA may have been significant. Yet, most had the feeling that it was difficult for NACA to obtain the Minister's attention.

In terms of concrete impacts on policy, the most popular example given by NACA interviewees was a meeting the Council had with the Minister of Finance prior to the tabling of the last federal budget. They felt that the Minister listened carefully to their policy position on pensions and related issues and that, in the end, the position of the government as articulated in the budget, was fairly consistent with NACA's.

Some NACA members and a few Health Canada officials felt that NACA's hit and miss success at drawing ministerial attention has led NACA to increasingly view stakeholders and seniors as its primary audience.

Increasing Society's Understanding and Acceptance of Aging and Seniors

Stakeholders had mixed views on DAS/S' success at promoting a positive and realistic image of seniors through research. Most said it was difficult to say, while others felt that publications, particularly those of NACA, were effective at puncturing myths and stereotypes through factual information and the depiction of real life situations.

Others who were interviewed tended to indicate that it was difficult to assess impacts in this area. Many also indicated that this issue was less important than others.

(c) DAS/S Internal Activities

The evaluation produced a number of useful findings with respect to the impacts and effects of DAS/S activities other than those discussed in the previous two sections.

A review of a sample of randomly selected DAS/S internal project files showed that the most prevalent need addressed by internal projects was health and well being. Independence and barriers to participation were also addressed by about one-half of reviewed projects. The most frequent target groups of internal project activities have been seniors in general or a mix of "other" people, such as the general public, health professionals, DAS/S program staff, NACA, policy researchers and federal and provincial Ministers.

The most frequent internal project activities related to the dissemination of information, followed by workshops, communications and knowledge development. Evidence that partnerships were developed was present in a majority of internal project files, particularly with respect to partnerships within Health Canada and other federal government departments.

The impacts and effects of DAS/S activities as documented in the internal files, varied widely. Key accomplishments include the following:

- ☐ research on disability-free years expectancy has been internationally recognized;
- ☐ the SIRP symposium on methodological diversity and quality in applied social and health research on aging and seniors' issues was considered to be extremely successful and innovative, leading among other things, to the creation of networking opportunities, particularly among policy makers and seniors' organizations;

- ☐ an *Inventory of SIRP Funded Projects;*
- ☐ the identification of valuable lessons from the Aging/Seniors Policy Review;
- ☐ a second edition of the resource guide for seniors; and
- ☐ the first meeting of federal/provincial/territorial Ministers responsible for seniors provided an opportunity for increased cooperation.

According to Health Canada officials, the Division has sponsored many meetings, fora, workshops, roundtables and conferences on a variety of topics and including a wide cross-section of stakeholders. For example, DAS/S' symposium on methodological diversity and quality in applied social and health research on aging and seniors' issues brought many policy-makers, researchers and stakeholders together. Opportunities for face-to-face networking are apparently rare and this conference was an excellent opportunity for people to meet and share information. The proceedings of the conference were published and made a significant contribution to the state of knowledge.

The *Seniors Guide to Federal Program and Services* was viewed as an important example of providing information directly to seniors. This guide has been regularly updated and reprinted to meet the strong demand from seniors and seniors organizations.

The review of internal files provided some information on leveraging and partnerships. Although there was some indication that partners may have contributed financially to projects, figures pertaining to financial contributions from partners were evident in only three of 30 reviewed files. Evidence of in-kind contributions was present in only two project files.

Providing Support to NACA

All who were consulted agreed that Division officials provided very good support to NACA. Examples of support provided to NACA include the provision of research papers and other materials, organizing council meetings, and facilitating access to the Minister. NACA members were particularly lavish in their praise of the support they received from Health Canada staff. The latter were described as "dedicated", "intelligent" and "hard working". For their part, Health Canada officials who provide support to NACA did not identify any problems in serving NACA.

Guiding the Development of Programs, Policies and Strategies

According to officials of central agencies, DAS/S has had only a minor impact on the policies/programs of other players, largely because it lacks a strong policy analytical group.

Health Canada personnel, however, generally had a more positive appraisal of the impact of DAS/S in this area. Some noted that through DAS/S's internal research and leadership, all governments have put more effort into identifying a knowledge base for policy formulation.

Health Canada officials also agreed that DAS/S has been successful at getting seniors' issues on the agenda of other federal departments and levels of governments. In addition, other federal departments have learned to consult directly with seniors on key issues.

The Interdepartmental Committee on Seniors Issues (IDCSI), led by Health Canada, coordinates efforts related seniors across the federal government. The Committee holds quarterly meetings on seniors' issues and includes representatives of 22 departments.

The interdepartmental committee is key to promoting awareness among federal departments. It is viewed by those who are familiar with the committee as a successful vehicle for information sharing and for creating opportunities for collaboration on projects across departments. There was consensus among IDCSI committee members that an interdepartmental committee around seniors issues is a useful and necessary organization. In general, IDCSI members agree that the committee has performed a valuable role in terms of information exchange and sharing experiences. The committee has permitted opportunities for members to understand the current initiatives of various departments and has raised awareness generally around seniors and aging issues.

The policy role of the committee will be strengthened in the future pending approval of new Terms of Reference. While they are yet to be finalized, the new Terms of Reference will likely provide some scope for the Committee to: 1) set priorities for policy and research and programs concerning seniors (based on a new Framework on Aging document); 2) monitor federal government activities against these priorities; and 3) manage cross-departmental files.

The recently developed *Framework on Aging* document was noted by a number of Health Canada representatives as an example of the Division's efforts to develop an integrated policy on aging. It includes a vision statement on aging and seniors' issues, policy principles and test questions, an inventory of policies and a monitoring system. This document is based on federal, provincial, and territorial consultation as well as extensive consultation with seniors. The document was endorsed by the Minister in June, 1996. At this time, not all elements of the Framework have been completed.

The views of provincial/territorial representatives as to whether the DAS/S has developed and promoted integrated policies and strategies were limited. A large number of respondents indicated simply not knowing. Others felt that if DAS/S had done this, the integration of policies was in its very early stages. One provincial/territorial representative, however, indicated that policy and program development was the major strength of the DAS/S. This respondent went on to say that the DAS had taken the lead role in the federal/provincial/territorial working group and the work they had done was outstanding.

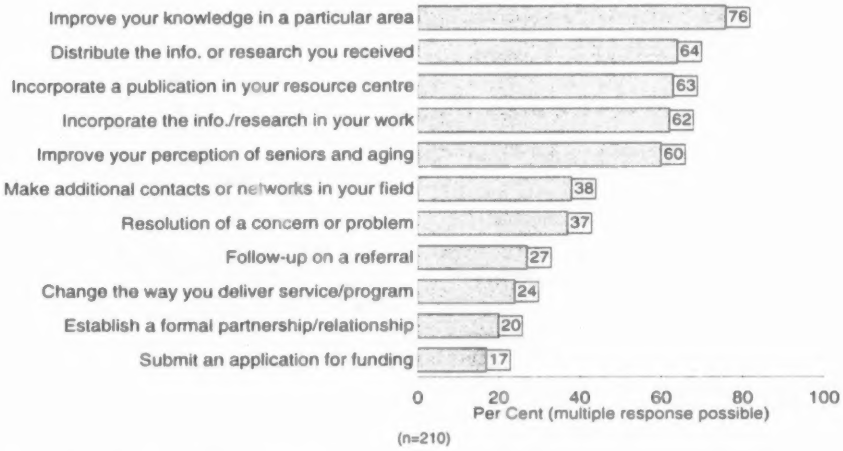
Increasing and Disseminating Knowledge and Resources

The majority of general public clients surveyed (61 per cent) contacted the Department on behalf of their organization. This suggests the possibility of a significant multiplier effect in information dissemination.

This is strongly corroborated by another finding from the survey. The impacts and effects of the program for general public clients were examined separately for clients who were seniors and for those who were not. As revealed in Exhibit 4.4, while increasing the knowledge of the non-senior was the most frequent impact, the other impacts were mainly related to dissemination of knowledge, or the incorporation of knowledge into broader work.

EXHIBIT 4.4
Program Impacts: Non-Seniors:
Views of General Public Clients

"What was the impact of the information, advice or referral you received through the aging and seniors programs at Health Canada?"



Source: DAS/S Evaluation, Survey of General Public Clients, 1996.

For the general public clients who were seniors, impacts and effects of contacts were similarly focused on raising personal awareness (e.g., about nutrition or physical exercise) and on facilitating their ability to disseminate accurate information to others.

It is also important to note that the information, advice or referral received by non-seniors among general public clients appears to have had a significant impact on improving recipients' perception of seniors and aging. A majority (60 per cent) of survey respondents identified this as an impact.

4.4 Unintended Impacts

Very little evidence of unintended impacts and effects was obtained in the evaluation. The file/documentation review and surveys yielded no evidence on this issue, and in the interviews most respondents observed *no* unintended impacts of DAS/S activities and projects.

A minority of interview respondents noted the following unintended, *positive* results:

- ☐ As a result of their participation in various projects, some seniors organizations have become effective lobbyists.
- ☐ Due to the success of projects, some seniors have become empowered to a greater extent than initially anticipated.
- ☐ The scope of a project was broadened without any additional cost.
- ☐ Awareness of seniors/aging issues was raised among an unanticipated target group, and relationships were developed with unanticipated partners.
- ☐ Some unintended spin-off effects were observed, such as the implementation of a project in another region.
- ☐ Due to their successful setting of priorities for the Population Health Strategy, DAS/S staff have served as a good model for other "life cycle" groups at Health Canada (i.e., groups focused on child/youth and midlife issues).

Unintended, *negative* impacts were also observed by a minority, including:

- ☐ Seniors organizations, which have received funds through community funding programs, can develop a dependency on financial support.

Once the available community funds have been used, these organizations may approach the provincial/territorial government for further funding, but are usually turned down.

- There has been some antagonism between funded and non-funded organizations due to the latter's perception of unfair proposal review/ funding decisions.
- Due to the greater ability and resources of larger organizations to prepare a good proposal and obtain funding, some smaller organizations have been having difficulty operating and accessing funding.
- Encouraging partnerships between organizations — which have a history of competing for funds — can exacerbate an already competitive relationship and result in conflicts.
- Staff of successful projects can sometimes feel that they are being penalized for their success when funding officials turn them down for further funding, arguing that their project should become more self-sufficient.

4.5 Strengths

One of the key strengths of DAS/S noted by respondents from all respondent groups is its staff. DAS/S staff were said to be knowledgeable, to have a high level of expertise, to be experienced and to be highly committed to seniors/aging issues. Another strength noted by regional Health Canada personnel, provincial/ territorial representatives, central agency officials and stakeholders has been the DAS/S's ability to raise the profile of seniors' issues and provide leadership to other federal departments as well as provincial/territorial governments on addressing seniors issues. The DAS/S is said to provide a federal focal point for seniors/aging issues. In a similar vein, some regional Health Canada personnel also commented on the synergy among the different elements of DAS/S and the closer relations among the different elements as a result of the shift in the structure of the DAS/S. This cohesiveness among elements was also noted by stakeholders as being a strength.

The funding activity of the DAS/S is also considered to be a strength (primarily by provincial/territorial representatives, stakeholders, funded and non-funded recipients) for a number of reasons. Funding in general means that money is made available for large projects that require substantial funding (i.e., community and research) as well as for research. For at least some of the respondents, the funding of research is very important because it is believed that if Health Canada doesn't do it, no one else will. Second, and perhaps more important than the actual funding itself, is the involvement of seniors in funded projects. The DAS/S is seen particularly by stakeholders and funded recipients as being very supportive of seniors involvement in its projects and activities. Along this same line, the DAS/S's ability to develop partnerships was also seen as a strength by stakeholders as well as funded and non-funded recipients.

DAS/S' publications as well as those of NACA were noted as strengths of the DAS/S by respondents from all respondent groups with the exception of central agency officials. The information contained in these publications is believed to be readable, relevant, well distributed and, according to some respondents (i.e., NACA members), the publications are also timely and topical.

Although not explicitly identified as a strength of the DAS/S by respondents, the fact that DAS/S has made it possible for many projects to be undertaken can be viewed as a strength. The majority of funding recipients interviewed for this study believe that their project would not have taken place if there had been no funding from DAS/S. A few respondents did feel that their project might have gone ahead, albeit at a much slower pace and not to the same extent. DAS/S funds had allowed their projects to reach more people and do more activities in a shorter amount of time. This belief is supported by non-funded applicants who reported that only a small minority of projects had been able to find funding from another source and that some projects were only completed in part.

Finally, the fact that the majority of New Horizons projects reviewed for this study (71 per cent) indicated either being self-sufficient or at least planned on being self-sufficient (i.e., taking steps towards that goal) can be seen as a strength of the DAS/S[36].

In terms of the DAS/S short term goals, the above strengths indicate that the DAS/S is addressing its short term goals of increasing and consolidating knowledge and providing seniors with the information they need to make informed choices. Through its funding programs, the DAS/S is addressing its long term strategic direction of eliminating barriers to the involvement and participation of seniors in society. The addressing of these short term goals and long term strategic directions may, in fact, impact on other short term goals (e.g., promoting a positive and realistic image of seniors) and long term strategic directions (e.g., increasing society's understanding and acceptance of seniors).

4.6 Weaknesses

There were three major weaknesses of the DAS/S noted by respondents: aspects of the funding process for community projects; profile; and coordination and communication. The lack of overall funding for seniors projects, as well as lack of on-going funding and funding for long term projects, was the most commonly cited weakness noted by all respondent groups with the exception of central agency officials, Health Canada managers at Headquarters and provincial/territorial representatives. In line with lack of funding, the lack of overall resources, including the DAS/S's human resources, was noted by regional Health Canada personnel and funding recipients.

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36. A smaller proportion of projects from the other programs indicated self-sufficiency (i.e., SIP — 28%; Ventures — 38%; NH:PA — 21%). This is partly due to a lack of information on self-sufficiency in the documents reviewed (e.g., only 9 out of 42 NH:PA projects had information on this issue).

The DAS/S's lack of profile was also noted as a serious weakness by the majority of respondent groups (i.e., with the exception of central agency officials and NACA). The DAS/S is not considered to have done a good job of making its activities or mandate known to the general public (i.e., outside of those associated with the programs or stakeholders). People may know specific programs (e.g., New Horizons), but they don't know what the DAS/S is, which activities it undertakes, how it may be of use to them (e.g., what funding is available) or how its activities may affect them. In addition to disseminating information on its activities, it was felt that DAS/S should be communicating its accomplishments to the rest of society. Given the number of activities undertaken by the DAS/S in which stakeholders were participants or partners (e.g., *Connection '95, Seniors Info-Exchange* newsletter, priority setting for NH:PA), it is interesting that stakeholders perceive the DAS/S to have a low profile. While still a perceived weakness, this "lack of profile" may be the result of all the reorganization and reorientation that has occurred during the life of both Strategies. It is difficult to effectively promote one's programs and objectives when the context is ever-changing. At this point, promoting the program is hindered by the lack of certainty about future directions for seniors and aging programming at Health Canada. Nevertheless, this is one area identified by respondents as needing to be addressed.

Although coordination was cited earlier as having been key to the successful lack of duplication of program and activities, study respondents also identified it as being the third major weakness. It was felt by some respondents that coordination and communication between DAS/S at Headquarters and the regions (noted by regional Health Canada personnel), between the provincial/territorial governments (noted by provincial/territorial representatives and non-funded applicants) and the federal government and among federal government departments (noted by central agency officials and stakeholders) could be improved. The creation of the Interdepartmental Committee and the setting up of Federal/Provincial/

Territorial meetings, however, are an indication that steps are being taken to address this weakness.

In addition to the above, there were other weaknesses cited on a less frequent basis. One weakness identified by stakeholders and funding recipients was the process for applying for funding. It was noted by some that the selection process for funding was very slow. This slowness creates problems for associations that have yearly budgets that must be spent. Others commented on the difficulty in filling out the application form for funding. It was also felt by some stakeholders that some of the requirements (e.g., "at risk") were too restrictive, resulting in some good projects not receiving funding. Finally the peer review process for community funding projects was criticised by some stakeholders for not being transparent and providing only limited feedback.

The lack of progress in drawing lessons learned from activities, particularly community funded projects, was a weakness cited by both Health Canada managers at Headquarters and regional Health Canada personnel. It was felt that there is a great deal of research and community-based learning that could be collected, synthesized and communicated, but too often projects come and go without being enveloped in a research framework. This opinion is somewhat supported by the experience of the analysts involved in the file review component of this study. In reviewing project files, very few evaluation reports or documentation on lessons learned were found in the files. This, however, is partly because not all programs required either a final report or an evaluation, some projects had just been completed and others were still on-going. Also, the fact that evaluations are now a requirement of New Horizons: Partners in Aging projects indicates that steps are being taken to address this weakness. The extent to which the information on lessons learned as collected during the project evaluations is communicated is yet to be seen.

A number of other weaknesses were also noted. Examples include:

- need for more synthesis in the area of research (regional Health Canada personnel);
- objectives and focus of DAS/S are too diffuse (central agency officials);
- "softer" health promotion strategies have not provided sufficient value for money (central agency officials);
- changes wrought by the changes in structure had a negative impact on program delivery — for example, community groups were confused by the changes and the requirement for innovation confused the application process (regional Health Canada personnel);
- more effort should be put into partnership building (stakeholders); and
- the former New Horizons program was seen by some Health Canada managers at Headquarters as not being very selective in the types of activities it funded. The perception is that this type of programming was no longer affordable for the federal government. It should be noted, however, that the "old" program was not designed to be selective or prescriptive in its projects as the criteria was "for and by seniors". This does not, however, mean New Horizons did not have positive impacts (e.g., provided social support). In fact, it was the view of stakeholders that New Horizons had been very beneficial and had addressed one of the main groups of "at risk" seniors — those without a social network.

Finally, the fact that only a minority of NH:PA projects (21 per cent), SIP projects (28 per cent) and Ventures projects (39 per cent) that were reviewed for this study indicated either being self-sufficient or at least taking steps towards self-sufficiency can be seen as a weakness of the DAS/S. It is important to note, however, that some of the projects may have been only "one time" projects and on-going projects may have not yet reached the point where the process for self-sufficiency had begun.

In terms of the DAS/S's short term goals, the above noted weaknesses suggest that there is still work which needs to be done in the areas of increasing and consolidating knowledge, and guiding the development of programs and strategies that are effective and address the needs of seniors. In terms of long term strategic directions, there is a need for more work to be done in eliminating barriers to the involvement and participation of seniors in society.

CHAPTER 5 ALTERNATIVES

5.1 Cost-Effectiveness of Programs/ Activities Supported by DAS/S

Most respondents from the various respondent groups who were interviewed for this evaluation had difficulty in providing an assessment of the cost-effectiveness of the programs and activities supported by DAS/S. The information that is available on the projects undertaken by DAS/S do not provide the kind of evaluation data to permit an analysis of costs and benefits. In general, respondents believed that the approach of DAS/S — to foster the health, well-being and independence of seniors — should lead to cost-effective results. Independence — being free of dependence on others — and high quality of life have important, positive implications for health care costs and, according to respondents, can decrease the expenditures on health and social services. Conventional wisdom also indicates that community-based care is less expensive and preferable to institutionalization. Baker (1988) points out that many authors suggest that major reforms rather than expansion are needed in the health care system to focus more on prevention, community and home care, and the use of a variety of practitioners. Self-help and self-care are offered by Baker as examples of low cost strategies which can improve health and living conditions (see also Smith and Longino, 1994 and Addleman, 1995).

Decentralization of seniors support services to the community is identified in the literature as an important long-term trend. Many experts in the field however, caution that the shift to informal supports and community-based services must be accompanied by adequate supports to avoid an increased burden on family caregivers and strains on the caring relationship (Walker, 1991). The expected increase in the seniors population demands that cost-effective intermediate care alternatives be made available to support families and community-based organizations in their care of the aging population. Examples include respite care, training for caregivers, daycare services for caregivers' children and transportation. According to Gee and McDaniel (1993), this support should be targeted towards middle-aged women who form the bulk of caregivers but are in need of assistance themselves. The authors note that policy-makers have taken this source of caregiving for granted and caregiver-support strategies should be developed. Health Canada and DAS/S may have a role to play in funding research to determine the cost-effectiveness of various community-based care approaches.

While there is broad agreement about the overall cost-effectiveness of healthy, independent aging and community-based care, there is little hard evidence available which examines the *relative* cost-effectiveness of the different elements or approaches of DAS/S which are designed to achieve these objectives. According to some key informants from Health Canada at headquarters, part of the challenge involved in estimating cost-effectiveness is that there are different objectives and time frames associated with the various activities and approaches that comprise DAS/S. For example, the impacts of research-oriented activities would be expected to mature over a much longer timeframe than community-based programs. On the other hand, while research may require an initial high cost investment, the results have the potential to influence the health and well-being of many seniors.

Many of these respondents noted further that the various approaches which are available to the program should be viewed as interconnected, with the effectiveness and cost-effectiveness of one component being dependent on the others. In other words, this "holistic" approach suggests that it would be misguided to rely exclusively on one or two relatively more cost-effective approaches at the expense of others, leading to a reduction in the overall cost-effectiveness of seniors programs.

While there was no consensus on the issue of cost-effectiveness, there was a tendency among some regional officials to feel that some of the research activities of SIRP were somewhat far removed from the practical needs of seniors, and that as a result, they might not be as cost-effective as DAS/S' other elements. All funding recipients believed that their programs were cost-effective because they rely on volunteers and partnerships.

The experts who were canvassed for this evaluation were also cautious in their comments about cost-effectiveness. Many noted the difficulty in measuring cost-effectiveness of human services or remarked on the lack of information to draw conclusions about cost-effectiveness. Two of the experts, however, noted that DAS/S has increased its cost-effectiveness with its recent evolution toward more targeted funding.

It should be noted that DAS/S does attempt to ensure the cost-effectiveness of activities at the "front-end" of many projects. For example, in community-based programming under the NH:PA, funding criteria are designed to ensure that projects are *needed* by the local seniors community and are innovative. The focus of the program on "at risk" seniors represents a significant evolution from the

New Horizons program. Similarly, funding for research under SIRP is awarded according to established priorities, using a peer review and/or competitive process. An advisory committee reviews and monitors the research to ensure that projects are achieving its milestones.

While hard evidence is lacking on the relative cost-effectiveness of programs, many interview respondents were, however, able to identify key factors which are associated with cost-effective and successful programs. Greater emphasis on these factors or the adjustment of current activities and programs to incorporate these features would, according to respondents, improve their overall cost-effectiveness. Based on the comments from all the respondent groups, five key factors affecting cost-effectiveness may be distilled:

- ❑ ***clear criteria, monitoring and accountability*** were cited as important factors in ensuring and improving cost-effectiveness. Criteria for funding of DAS/S programs and activities should emphasize *need*. As well, there should be a clear understanding of the minimum resources required to satisfy identified needs. "Need" was identified as a factor particularly relevant to the design and delivery of community-based funding programs. Monitoring and accountability of programs and activities protect public investments and also provides valuable information on lessons learned which may be transferable to other programs and activities.

- ❑ ***information sharing/economies of scale*** avoids needless investment of resources into programs, activities and products that have been developed or tested in other settings. "Reinventing the wheel" by various jurisdictions or program/agencies is costly. To the extent that information is shared and investments in programs are incremental, cost-effectiveness is improved.

- ❑ ***outreach*** was identified as a key determinant of cost-effectiveness. For example, programs and activities which result in tangible information or products (e.g., publications, videos, training materials) can be distributed at little incremental cost and can reach a very wide audience.

- ❑ ***programs and activities emphasizing prevention*** are viewed as being very cost-effective. While treatment approaches can never be eliminated, many observers believe that current policies focus on sick seniors to the exclusion of the "well" elderly. The literature in this area indicates a need to focus greater resources on prevention through a variety of strategies such as self-help and self-care. It is well known that prevention (e.g., of injury or illness) is less expensive than treatment after the fact.
- ❑ ***use of partnerships/sponsorships,*** while initially expensive and time consuming, is viewed as paying dividends in the long term by providing additional human and financial resources to projects. Partnerships with the private sector were mentioned by some as an area where DAS/S could improve. In a similar vein, some respondents suggested that DAS/S strongly encourage the use of volunteers in its projects to improve cost-effectiveness.

The principles outlined by key informants do not imply a fundamental change in DAS/S to improve cost-effectiveness. In fact, one expert noted that, while in agreement with the above principles, these would be expected to yield only modest improvements. To a great extent, DAS/S has incorporated all of these principles in current projects. As mentioned above, funding approval for community-based projects and research initiatives are based on established criteria or priorities. Chapter Four also highlighted the varied products that have been developed and disseminated by DAS/S. These products have typically been developed with the assistance of partners and have resulted in products that have been distributed to organizations, governments, and seniors themselves. NACA and community funding programs make extensive use of volunteers in their programs to ensure cost-effectiveness.

If there are weaknesses in the extent to which these principles are incorporated into DAS/S activities, it is in the areas of accountability and monitoring, information sharing and partnerships. Central agency personnel who were interviewed identified a need to clarify the objectives of DAS/S, as well as its projects to pave the way for greater ongoing monitoring and evaluation of the achievement of objectives.

In terms of information sharing, some respondents, particularly regional staff and provincial/territorial representatives have suggested the need for greater communication with Health Canada personnel at headquarters. Marshall (1993) has also called for greater coordination of aging and health policy initiatives at federal, provincial and local levels. Marshall argues for both greater coordination and improved flow of data across jurisdictions. The structures for information sharing both formal and informal, appear to be in place, but there is a need to continue to expand the lines of communication between Ottawa and regional and provincial/territorial interests. The third area — partnerships — was noted by some stakeholders and provincial/territorial respondents as an area which could be further improved. Partnerships and the use of volunteers is certainly a key aspect of many DAS/S projects now. Stakeholders and provincial/territorial respondents recommended that this activity be further expanded. Partnerships with the private sector were identified as an avenue that has yet to be fully explored.

The opinions of the study experts were also canvassed to examine ways of improving the cost-effectiveness of DAS/S. Their suggestions echoed and expanded many of the principles identified above. The comments included: greater monitoring, greater attention to "up-front" setting of priorities based on consultation, with seniors and other organizations; and stronger structural linkages or partnerships with research funding organizations, foundations and the private sector.

5.2 Essential Areas for DAS/S Involvement

Given the involvement of other federal government departments, provincial/territorial governments and non-government organizations, all respondents were asked whether Health Canada should continue to maintain all of its activities under the DAS/S. Specifically, respondents were asked to identify those areas of the

DAS/S which they felt were essential to retain and areas which were discretionary or could be handed over to other government or non-government organizations currently involved in the DAS/S or in initiatives similar to DAS/S.

There was a general feeling among DAS/S personnel, stakeholders and intended beneficiaries that virtually all areas in which DAS/S is currently involved should be retained. Moreover, many of these respondents also expressed the importance of maintaining the Division or something similar to it "intact". Health Canada personnel, for example, felt that it would be myopic for the federal government to fail to capitalize on the expertise, experience and contacts which have been accumulated in DAS. The Division was viewed as necessary and which, if diluted now, would simply have to be reconstituted in the future as aging and seniors issues increase in prominence. Stakeholders, as well, favoured the existence of a government umbrella organization or single structure which would house the various components of a seniors and aging strategy. Several experts emphasized the benefit of and need for a centre of expertise on seniors and aging issues which would be recognized both inside and outside of government.

The areas currently covered by DAS/S which respondents believed to be essential or areas that DAS/S should definitely retain closely mirror the roles that key informants identified as appropriate for the federal government and Health Canada to play in terms of seniors and aging issues. These areas also generated a high level of consensus among respondents within each of the groups. Among those areas which were consistently identified as being essential areas for DAS/S to retain are:

- ☐ ***research***. For the vast majority of respondents in all groups, research was an important and very successful component of DAS/S. This is an area where the federal government could continue to add a great deal of value by playing the lead role in setting the research agenda, funding, coordinating partnerships and disseminating results. National level research ensures that data across provincial/territorial jurisdictions are comparable.

- ***policy***. Developing and guiding policy at a national level was widely identified as an essential area for Health Canada and DAS/S to retain. There was strong agreement that there is a need for a group of experts that could provide an overall national framework for the formulation of policy and the identification of supporting research needs for seniors and aging issues. The policy work of NACA and the Division were identified as essential areas.

- ***coordination and facilitation***. According to many respondents, including central agency personnel, Health Canada personnel, provincial/territorial representatives, and DAS/S stakeholders, Health Canada and DAS should retain their role in terms of coordination of seniors programs and activities, both within the federal government and across other government jurisdictions and non-government organizations.

- ***information sharing***. Information sharing is considered to be an important role by both those within the Department and outside. The access of DAS/S to expertise gives it an advantage in terms of consolidating information. Information should continue to be disseminated to provinces/territories, other organizations and, where appropriate, to seniors themselves.

- ***funding of community-based programs***. There was less consensus across the groups in the area of funding of community programs. However, provincial and territorial officials, as well as some stakeholders believed that the federal government should maintain its funding role for seniors community-based programs. Some provincial/territorial representatives and HC regional personnel suggested that provinces/territories and communities could assume greater responsibility in administering the funding to recipients, however, this was not consistent across all regions. This is likely due to variability in the staffing and financial resources available in the various jurisdictions.

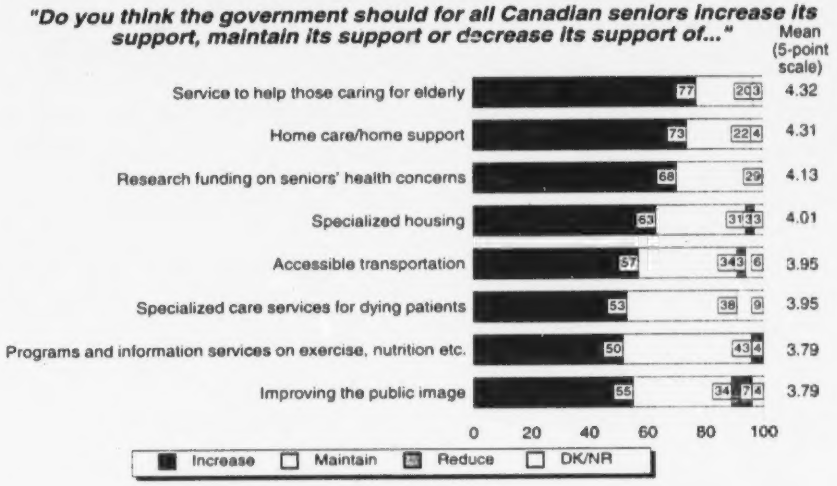
Surveyed general public clients of DAS/S and intended beneficiaries of community-based programs were asked to identify priorities for government in the area of seniors and aging issues. Specifically, respondents were asked to rate whether government should increase, maintain or reduce its level of support for a variety of different programs and services affecting seniors. These programs and services cut across a number of federal government departments and across federal and provincial/

territorial jurisdiction. Exhibits 5.1a and 5.1b present these findings for the survey of general public clients. The results for the survey of intended beneficiaries are presented in Exhibits 5.2a and 5.2b. For both respondent groups there were, overall, few areas identified where government should reduce its support. The exception is health care benefits for out-of-country care where just under one-third of general public respondents and 18 per cent of intended beneficiaries felt government could reduce its level of support. For the remaining issues, respondents generally believed government should at least maintain its support. In general, the intended beneficiaries of DAS/S were less likely than general public clients to favour increasing government support for the various services tested. For example, whereas general public clients favoured increasing government support in nine of the 16 services tested, intended beneficiaries believed government should increase support for only three of these services. Within the general public client group, non-seniors were more likely than seniors to prefer that government increase support for the services listed.

Health issues are clearly an important priority for both respondent groups. However, only selected topics under this broad area were considered to merit increased support. For example, the majority of general public clients and intended beneficiaries believe government should maintain, not increase, its level of support for basic health care coverage and extended benefits for prescription drugs or out-of-country care. However, funding for research on seniors' health concerns was a health-related issue which appeared at the top or near the top of the priority list for both general public clients and intended beneficiaries. Issues around care of seniors in the home are also of prime importance. Caregiver support and home care/home support services are two areas where both general public clients and intended beneficiaries believe government should increase its support.

EXHIBIT 5.1a
Priorities for Government: Views of General Public Clients (I)

"Do you think the government should for all Canadian seniors increase its support, maintain its support or decrease its support of..."

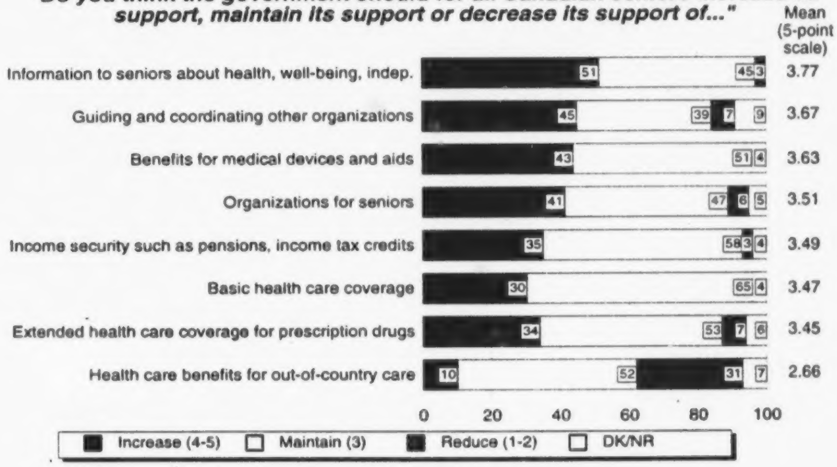


(n=291)

Note: Numbers under 2 are not displayed in the graphic.
Source: DAS/S Evaluation, Survey of General Public Clients, 1996.

EXHIBIT 5.1b
Priorities for Government: Views of General Public Clients (II)

"Do you think the government should for all Canadian seniors increase its support, maintain its support or decrease its support of..."

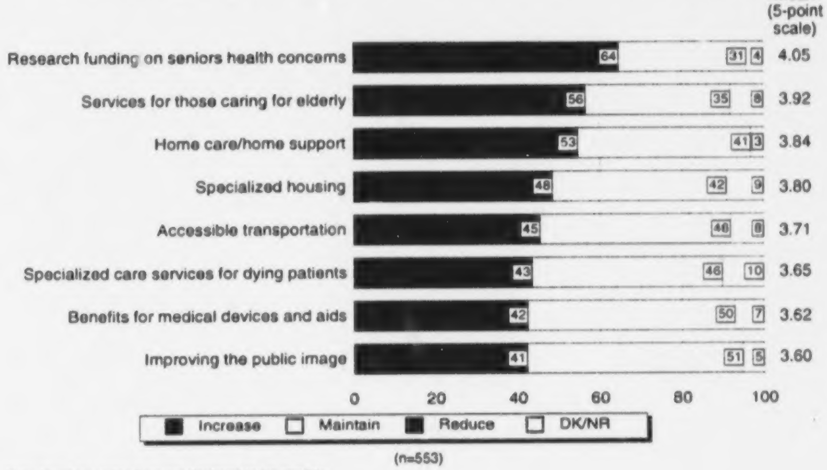


(n=291)

Note: Numbers under 2 are not displayed in the graphic.
Source: DAS/S Evaluation, Survey of General Public Clients, 1996.

EXHIBIT 5.2a
Priorities for Government (I)

"Should the government increase, maintain or reduce its support of...?"

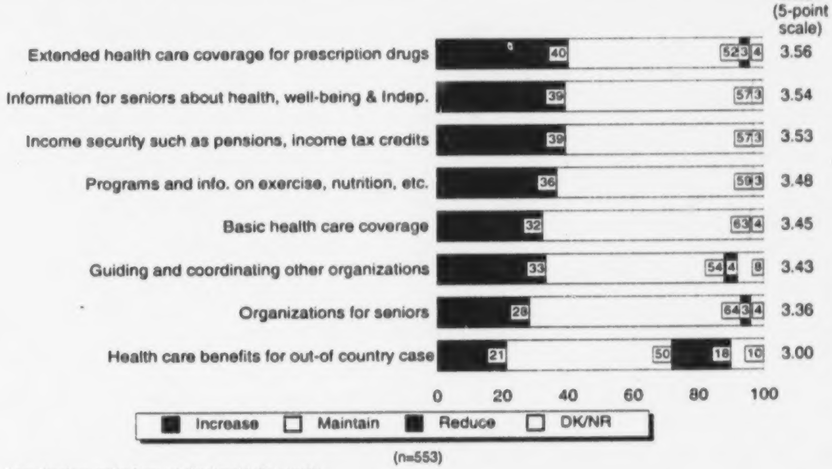


Note: Numbers under 2 are not displayed in the graphic.

Source: DAS/S Evaluation, Survey of Intended Beneficiaries, 1996.

EXHIBIT 5.2b
Priorities for Government (II)

"Should the government increase, maintain or reduce its support of...?"



Note: Numbers under 2 are not displayed in the graphic.

Source: DAS/S Evaluation, Survey of Intended Beneficiaries, 1996.

Moving down the priority list for both respondent groups are specialized housing for seniors, accessible transportation and palliative care services. Services related to provision of information and communications received a middle priority, with general public clients being somewhat more likely than intended beneficiaries to favour an increase in government support for program's such as for wellness programs and information and providing information to seniors about health, well-being and independence.

Within the intended beneficiary group, female respondents are more likely than male respondents to want increased support for caregiver services, home support/home care services and accessible transportation. Financially insecure respondents were more likely than those with greater financial resources to prefer an increase in support in areas such as home care and home support services, extended health care benefits for prescription drugs, providing information to seniors about health, well-being and independence, income security programs such as pensions and income tax credits and basic health care coverage.

The priorities rated by general public clients and intended beneficiaries of DAS/S are not strictly comparable with the comments from key informants. Whereas key informants focused on essential areas for Health Canada, and for DAS/S in particular, survey respondents rated a series of items on government involvement which cut across federal and provincial/territorial governments and across government departments. Nevertheless, it is important to note that research on seniors and aging issues is considered to be important by both key informants and surveyed groups. Not surprisingly, surveyed groups place a higher priority on more tangible or direct intervention services such as home care, housing and transportation. While information dissemination and coordination were identified as essential areas for the DAS/S by key informants, these somewhat less visible or tangible activities were viewed as being less important by surveyed groups. Similarly, while prevention and health promotion activities were viewed by key informants as an important priority for DAS/S and a cost-effective approach, surveyed groups rated these areas a lower priority compared to direct care activities.

The general public survey of Canadians conducted through the *Rethinking Government* project also asked respondents to choose the top priority for governments in terms of allocating health care resources among a series of suggested options. While the list of options represented a "forced choice" (rather than the scaled response for DAS/S participants) and the list of options was not as extensive, the results shows some similarities. Like the DAS/S participants, the general public recognize the importance of support for informal or community-based care. For example, home care and home support services was selected most frequently by general public respondents (58 per cent). The remaining options, in their order of priority were prescription drugs (20 per cent); nursing homes (13 per cent); and medical devices and aids (6 per cent).

5.3 Non-Essential Areas for DAS/S Involvement

Several of the respondent groups were very reluctant to identify any areas of DAS/S which were non-essential, and comments about non-essential areas did not generate the same number of responses of the level of consensus across respondent groups as essential areas. For example, virtually all Health Canada personnel and stakeholders had difficulty identifying any areas from which DAS/S could withdraw or that could be handed over to other government or non-government agencies or departments. Rather, these respondents emphasized that the DAS/S should be treated as an *integrated* program, with each area benefiting from the others. The strategy is viewed holistically — the effectiveness of the levers available to DAS/S being dependent on one another. Removing some program activities was predicted to have a negative impact on others and, for the most part, these respondents preferred that no activity be cut entirely.

These respondents further warned that withdrawal of DAS/S from program areas would not necessarily mean these activities or programs would be taken up by other organizations. For example, provincial and territorial governments, facing the same fiscal restraints as the federal government, would likely be unable to replace programs or activities which are currently the responsibility of DAS/S. Provincial/territorial representatives confirmed that while programs such as seniors community funding programs could be ably administered by the provinces/territories, in most cases, the funding would still have to be provided by Health Canada as the provinces/territories do not have the resources. This was particularly true of the "have not" provinces, for example, in the Atlantic.

Key informants from other respondent groups, however, believed that the community funding programs in which DAS/S is currently involved could be considered a non-essential area for DAS/S involvement. A few Health Canada personnel and several federal government staff outside of Health Canada (i.e., central agency personnel and IDCSI members) raised this issue. Overall, the trend of the federal government toward devolution of responsibility to other jurisdictions suggested to these respondents that community-based programs are inconsistent with the current direction of the government and are areas where the program could withdraw some of its attention. Some of these respondents also argued that provincial/territorial governments and communities should more properly assume responsibility for funding programs of this nature. These jurisdictions, with their closer proximity to the program recipients, would be better able to assess needs, determine and implement responses and examine results. DAS/S could continue to contribute to effective delivery across provinces by providing some tools or a framework for delivery by these other jurisdictions. For example, these respondents suggested that in the area of community funding programs, the DAS/S should focus more on funding demonstration projects, evaluating them and disseminating the results in order to promote the development of successful approaches.

Three of the experts also suggested that funding for community programs be adjusted. One expert suggested that federal funds be available for evaluation purposes only. A second expert suggested that funds be made available more selectively, with the federal government being the funder of "last resort". A third suggested that DAS/S divest itself of this role entirely.

Other areas which were mentioned with less frequency by individuals from various respondent groups as non-essential for DAS/S involvement included: public image-related projects; projects that are outside the "bread and butter" concerns of the Division or provide little value for money and areas not strictly related to health (e.g., poverty, employment).

The responses of general public clients and intended beneficiaries do not support withdrawal of services in any area. However, the relative rankings of the items listed indicate that, in social and health-related areas, public image activities, information dissemination and funding of organizations for seniors are *relatively* less important concerns.

5.4 Alternative Program Mechanisms and Structures

Overall, there were very few recommendations for new or alternative program mechanisms and structures for DAS/S. The extent to which responsibility for aspects of DAS/S could be assumed by the provinces was examined in the key informant interviews. Areas such as research and policy analysis or policy coordination were generally not suggested by respondents as potential candidates for devolution to the provinces. There are, according to respondents, compelling reasons to maintain a national perspective in these areas. For example, nationally consistent research data is important both in terms of preserving the quality of research and taking advantage of economies of scale. The federal government also has access to expertise "in house" and externally, as well as the credibility to develop and coordinate policy around seniors and aging issues.

As mentioned above, key informants from some respondent groups indicated that responsibility for community funding programs for seniors could be devolved to provincial/territorial governments or to communities. Again, decisions around development of funding criteria, administration of funds and implementation were felt to be better suited to the needs of the community if they were made closer to the community. However, there were mixed views among these respondents about the devolution of responsibility for funding of community programs. Federal officials who held this view generally favoured devolution of all aspects of seniors community programs. Regional and provincial/territorial respondents, on the other hand, typically viewed devolution in terms of greater responsibility for decision-making, but retention of the federal role for funding. Again, these respondents believed that federal withdrawal from funding for community-based programs would likely not be replaced by provincial or community funding.

Other suggestions for alternative program mechanisms and structures revolved around two broad themes: location of DAS within the Department and maintaining the consolidation of different program components under one seniors and aging strategy. In terms of the former, several Health Canada personnel and members of NACA indicated that the organizational location of DAS within Health Canada limited the ability of the Division to directly communicate to and have input into ministerial decisions around seniors and aging issues. The perceived growing importance of seniors and aging issues should be better reflected in the structure of the Division and its access to public policy making. Two of the experts echoed this view, arguing for a more central organizational location for DAS to increase its visibility both inside and outside of the government and its identification as the primary centre of policy/research on seniors and aging issues.

In terms of the latter — the positioning of seniors and aging program components under one structure — most Health Canada personnel, stakeholders and funding recipients tended to favour the current structure of DAS which concentrates expertise and resources under one strategy. This structure was viewed as leading to greater exchange, stronger products and services and efficiencies in resources.

Other isolated suggestions for alternative program mechanisms and structures mentioned with less frequency included: giving more responsibility (and administrative duties) for community services to networks of NGOs; shifting some DAS/S program resources to operations to permit greater internal policy development; exploring alternative, more cost-effective methods of communication; devolving research activities to existing research bodies; and better coordination with other departments.

Under the issue of alternative program mechanisms and structures, is the question of the role of DAS/S in the future organization of Health Canada. As one of its four main business lines, Health Canada has adopted a Population Health Strategy (Health Canada, 1995e). The population health approach focuses on the entire range of individual and collective factors and conditions (including individual characteristics, social and economic factors, and physical environments), as well as the complex interactions among these, that determine the health and well-being of Canadians (Federal/Provincial/Territorial Advisory Committee on Population Health, September 1994). Strategies to improve population health are based on an assessment of all factors and conditions of risk and benefit that may apply across the entire population, or to particular sub-groups within the population. It is also assumed that improving health is a shared responsibility that requires the development of healthy public policies in areas outside the traditional health system, as well as collaboration among different sectors and levels of government.

With the Population Health Strategy, Health Canada uses an evidence-based approach to identifying and focusing its investments on the conditions that exert the greatest influence on the health of the Canadian population. This approach also incorporates a life cycle framework, whereby population health programming is tailored to the unique health determinants and needs at three stages of life — children and youth, midlife and later life.

Health Canada personnel and the central agencies who were interviewed for this evaluation were asked how DAS/S fits in with this new direction at Health Canada, especially the Population Health Strategy. While some respondents noted that the details of the strategy and its organization had yet to be finalized, most respondents believed DAS/S was very compatible with the population strategy. According to these respondents, DAS/S is based now on a "determinants of health approach". The Population Health Strategy will add greater conceptual clarity and a multisectoral perspective to the current activities of the strategy. Health Canada respondents suggested that the DAS/S, remaining intact within the Population Health Strategy, would address health issues around the "later life" stage.

5.5 Other Improvements to DAS/S

The literature on addressing seniors' needs shows that seniors and aging issues must be addressed using a systemic perspective, recognizing the interdependency of public policy. In general terms, Marshall (1993) proposes the following four guiding principles for an appropriate framework for public policy on aging and health:

- ☐ Policy must be multisectoral. Health depends on economy, nutrition, housing, environment and education.
- ☐ There must be a commitment to equity.
- ☐ Health public policy initiatives should, ideally, be broadly participatory.
- ☐ Policy must have an ecological perspective which places humans in a broad context of the physical and social world.

All key informant interview respondents were asked to provide suggestions for improvements to DAS/S. While there was great variety in the comments, the themes which emerged closely parallel some of Marshall's recommendations listed above. Themes which emerged with greater frequency include: coordination, planning, partnerships and evaluation. These are discussed below.

Several stakeholders and funding recipients called for greater coordination of programs across the federal government and between the federal government and provincial/territorial governments. In particular, it was recommended that Human Resources Development Canada and Health Canada have a closer working relationship which would allow the departments to better address, for example, the relationship between income security and health, well-being and independence. Greater coordination can also reduce any overlap and provide a more coherent response to seniors and aging issues.

Some stakeholders and funding recipients recommended that the DAS/S incorporate a longer-term, more planned view in terms of its funding decisions and allocations. For example, some respondents noted that funding that is available at both the federal and provincial/territorial levels allows for seed funding, but ongoing resources are often not available for the continuation of projects. Further, DAS/S should raise awareness as to the programs now available to potential applicants and be more visible as a source of information.

Other suggestions revolved around the need for DAS/S to establish more partnerships with external organizations. Some believed that seniors should have a greater role in directing policy and that more avenues should be available to receive public input into decision-making on aging and seniors issues. Others believed that DAS/S could improve its partnerships with the private sector, non-government organizations and academia.

Finally, several respondents mentioned that DAS/S could be improved through more rigorous and realistic objectives. These respondents, primarily within the federal government but outside of Health Canada, believed that DAS/S could better manage expectations by translating the current conceptual approach to seniors and aging issues into measurable operational objectives. An evaluation strategy could then be implemented to assess various elements of the strategy or projects funded by the program.

CHAPTER 6

CONCLUSIONS

Based on the integration of findings from the various data collection exercises, as presented in the preceding chapters, the following conclusions are presented.

6.1 Relevance

Despite advancements made in some areas (e.g., the public pension system), seniors in Canada still find themselves in situations of potential risk. For example, many seniors live below the poverty line and most require increasing assistance with daily living as they age. The literature also indicates that some seniors are more at risk than others, especially those living with limited income (who are mostly women), those living in isolated or rural areas, and Aboriginal seniors.

Most respondents to the various data collection methods used for this evaluation agreed that the federal government's role in seniors' issues is quite relevant. According to respondents, the federal government, and Health Canada and DAS/S in particular, have a relevant role regarding policy coordination, intra-governmental coordination, information gathering — including research — and dissemination, prevention and health promotion, and an advocacy and awareness raising role.

Some interview respondents questioned the relevance of some DAS/S activities. On the one hand, some questioned the research activities because they were seen as expensive and not always useful to seniors; on the other hand, a few respondents felt that DAS/S should not fund community activities. According to these respondents, since the provinces/territories are closer to seniors and this role is considered to be more in the line of service delivery, community funded projects were considered to be more of a provincial/territorial role (although comments were made concerning a belief that continued federal funding would likely still be needed).

The perceived relevance of DAS/S, especially with respect to its activities regarding community projects, varies according to region and the level of programs and services available in each area. The provincial/territorial structures that address seniors' issues vary considerably from one case to another and interviews suggest that health and community services are more extensive in some provinces than in others. As well, although most provincial/territorial respondents feel that both levels of government operating at a regional level collaborate and complement each other rather successfully, some respondents identified communication gaps between the federal and provincial/territorial authorities working at the regional level. In some provinces/territories, this could lead to some duplication of effort. Since the results show that the perceived relevance of the federal government role varies by province/territory, the differences in health and community services by region and communication gaps at the regional level should both be considered when assessing the federal government's role in seniors' issues.

6.2 Program Accomplishments

(a) Service Delivery

Two components of service delivery were examined in this evaluation. The first refers to enquiries made by general public clients and the second to the procedures to which project funding applicants must comply. Findings show that the majority of those who contact DAS/S to obtain information are satisfied with the result and most received the requested information. The successful and unsuccessful funding applicants, however, gave mixed views about the procedures that lead to and follow the process of project selection for funding. The majority feel that the allocated time to complete the application form is too short and that the waiting time to obtain the decision is too long. According to respondents, these constraints are very difficult to manage for NGOs. Most feel, however, that the level of funding and the support from Health Canada personnel is adequate, particularly in light of budget cuts in government.

(b) Coordination

The interview respondents offered mixed views about the accomplishments of the coordination activities of DAS/S. Although there is acknowledgement that there have been improvements over the last few years, especially following the creation of the IDCSI and the development of the Framework on Aging, many regional authorities, both from the federal and provincial/territorial departments, feel that the coordination activities could be improved.

(c) Partnerships

The file review findings show that the changes in community funding programs which occurred in 1993 and 1995 have significantly increased the number of partnerships between the funded organizations and other groups. The interview results confirm that many currently funded projects involve partnerships between NGOs, researchers, government and other partners. Partnerships with the private sector, however, remain a challenging task. As well, some seniors' organizations feel that DAS/S could work more in partnership with them.

(d) Community Funding Programs

The focus of NH:PA on targeting seniors at risk is reflected in the finding that a relatively higher proportion of its intended beneficiaries are economically disadvantaged compared to the intended beneficiaries of the other four programs overall. NH:PA's targeting is a particularly significant improvement over SIP's targeting, which aimed at seniors "in need", but which in fact failed to do so in practise, according to the survey of intended beneficiaries.

Overall, community funding programs seem to have improved the health, well being and independence of seniors. About three-quarters of surveyed intended beneficiaries said that they had felt a positive impact. These impacts were mainly at the level of improved mental well being. The survey revealed that the improved targeting did not translate into more significant impacts, however. The evidence suggests that this might be due to the fact that most NH:PA projects, like those under other programs, focus on improving the *mental* well-being of intended beneficiaries, as opposed to their economic status; the key characteristic that places these beneficiaries at greater risk.

Leveraging and partnerships have played an important role in community funding projects and have allowed a number of projects to either become self-sufficient or to adopt self-sufficiency as a goal. The project files did not shed much light on the nature or quality of partnerships, however.

(e) Research Programs

SIRP and NACA have been successful at producing high quality research and at disseminating this information to policy makers, researchers and stakeholders. According to the file review and to those who were interviewed as part of this evaluation, the programs have also had a positive impact on influencing policy. The evaluation evidence and expert opinion also suggests that SIRP was particularly successful at fostering partnerships.

While these programs were not designed to provide information directly to individual seniors, many commentators observed that some of the information they produce could be very useful and interesting to individual seniors, particularly NACA outputs. Clearly, NGOs and seniors groups, and, perhaps to a lesser extent, provincial/territorial governments, are intended to be the disseminators of relevant NACA and SIRP information to individual seniors. This evaluation suggests, however, that there is some question about the extent to which information is "filtering down" to individuals. It may be appropriate to engage stakeholders in discussions aimed at developing a more systematic strategy to disseminate NACA and SIRP information (where appropriate) to individual seniors.

NACA's main objective is to advise the Minister. This evaluation revealed that NACA has been moderately successful at influencing policy at this level. Evidence also suggests that NACA may have progressively come to see stakeholders and seniors in general as their primary audience, at least in part due to the perception of some NACA members that the Minister's attention was difficult to obtain. In the absence of more formalized methods of communicating with the Minister, it may be useful, given the finding discussed in the above paragraph, for NACA's relationship with seniors groups and stakeholders to be given more prominence as a stated objective.

(f) DAS/S Internal Activities

While there is some conflicting evidence concerning the impact of DAS/S' "internal" activities on policy coordination and promotion, a preponderance of evidence indicates that DAS/S did have a significant positive impact in this area. The Interdepartmental Committee on Seniors Issues was seen by many as key in promoting awareness of seniors' issues across federal departments.

There was consensus that DAS's support of NACA activities was very significant and positive. Finally, the survey of general public clients suggests that the information which was disseminated by DAS is, in turn, disseminated to others by the original recipients of this information.

6.3 Alternatives

(a) Cost-Effectiveness

There is a general consensus among respondents and in the literature that healthy aging and independence of seniors have positive impacts on health and social expenditures. However, there is little hard evidence on what types of approaches to foster health, well-being and independence are most cost-effective in achieving objectives. Some argue that there is a need for multiple approaches.

Study participants identified a number of factors which would improve the cost-effectiveness of programs and activities. These are: clear criteria, monitoring and accountability, information sharing/economies of scale, outreach, prevention, and use of partnerships/sponsorships.

(b) Essential Areas for DAS/S Involvement

The areas which were identified as essential for DAS/S to retain closely paralleled the types of roles which were identified as relevant for the federal government and Health Canada to play in terms of seniors and aging issues in general. Essential areas include: research; policy development and guidance such as framework development and the identification of emerging research and program needs; coordination and facilitation of the efforts of the federal government, provincial/territorial governments and non-governmental organizations; information sharing; and, according to provincial/territorial officials and stakeholders, funding.

General public clients and intended beneficiaries were asked to prioritize a series of programs and services for seniors, rating whether the government should increase, maintain or decrease its support for each one. The responses of the two groups were quite similar, with research funding for seniors' health care issues, home care/home support services and services to help those caring for the elderly topping the list of programs and activities tested. Further, health care was identified as a top priority for government involvement in the area of seniors and aging in a survey of the Canadian public.

(c) Non-Essential Areas for DAS/S Involvement

Key informants in some respondent groups, particularly Health Canada personnel and stakeholders, had difficulty identifying any areas which are not essential for DAS/S. Further, these respondents warned that withdrawal of the federal government from any of the areas currently covered by the DAS/S would likely leave a vacuum given that provincial and territorial governments would be financially unable to continue these services themselves. Some respondents, particularly federal personnel outside of Health Canada and several expert panellists, mentioned community funding programs as non-essential. These programs were viewed as being contrary with federal government devolution of responsibility and were seen by some as being more effectively delivered by other jurisdictions closer to the communities themselves. Some provincial/territorial representatives believed that the federal government should continue to fund community programs, however, provincial/territorial jurisdictions could increase their responsibilities in terms of program management.

(d) Alternative Program Mechanisms and Structures

There were few recommendations for new or alternative program mechanisms and structures for DAS/S. The comments that were received revolved around two themes. The first related to the location of DAS within Health Canada. Several respondents, within and outside of the Division, felt that the Division did not have the organizational profile and access to policy decisions that it should. Second, respondents suggested that the general structure of the Division should remain intact. The consolidation of the different areas of expertise and experience was viewed as an important advantage of the Division.

Health Canada and central agency personnel were asked how DAS/S would fit in the Department's Population Health Strategy. Respondents generally agreed that DAS/S is compatible with the Population Health Strategy and would be able to address health issues in the later life stage.

(e) Other Improvements to DAS/S

Several stakeholders called for improvements in the coordination of programs across the federal government and between the federal government and provincial/territorial governments. Respondents in these groups also suggested that the current funding structure be reviewed with more options available to support longer-term funding (rather than the seed funding which, according to respondents, has been where funding is concentrated). Study participants believed that the DAS/S could establish more partnerships. These partnerships could be with the private sector, education institutions and non-government organizations. Seniors themselves could also be given options to provide input into seniors policy. Finally, DAS/S could be improved by refining its current conceptual approach into more rigorous objectives that permit evaluation. There is a need for greater attention to project-level evaluations.

These evaluations, conducted on a regular basis, would allow DAS to assess the extent to which projects are achieving milestones and to examine impacts and cost-effectiveness of various approaches. Expectations around the capacity of DAS/S and the federal government to address seniors and aging issues must also be better managed.

APPENDIX A
Abbreviations

ABBREVIATIONS

BNA	British North America
CARNET	Canadian Research Network
CASPAC	Canadian Seniors Packaging Advisory Council
CATI	Computer Assisted Telephone Interviewer
CCSD	Canadian Council on Social Development
CDS	Canada's Drug Strategy
CHST	Canada Health and Social Transfer
CIS	Contribution Information System
CPP	Canada Pension Plan
CRA	Community Researcher Award
DAS	Division of Aging and Seniors
DAS/S	Division of Aging and Seniors/Seniors Strategy
DIAND	Department of Indian Affairs and Northern Development
GIS	Guaranteed Income Supplement
HC	Health Canada
HPPBRO	Health Promotion and Programs Branch Regional Offices

HRDC	Human Resources Development Canada
IDCSI	Interdepartmental Committee on Seniors' Issues
LCDC	Laboratory Centre for Disease Control
MRC	Medical Research Council
NACA	National Advisory Council on Aging
NGO	Non-governmental Organization
NH	New Horizons Program
NH:PA	New Horizons: Partners in Aging Program
NHRDP	National Health Research and Development Program
NSERC	National Science and Engineering Research Council
NWG	National Welfare Grants
OAS	Old Age Security
PAR	Program of Applied Research
PCB	Policy and Consulation Branch
SCP	Seniors' Community Program
SIP	Seniors Independence Program
SIRP	Seniors Independence Research Program
SITS	Seniors Inquiry Tracking System

APPENDIX B
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APPENDIX C
File Review Data Collection Form

DAS/S Evaluation File Review Guide

1: **DOCUM**

Indicate which program file documents have been received

01	Funding Approval form	01	
02	Application	02	
03	Activity and Accounting Report	03	
04	Impact Questionnaire	04	
05	Interim Reports	05	
06	Quarterly Narratives	06	
07	Final Report	07	
08	Evaluation Report	08	
09	Other	09	O
10	PROPOSAL (PART/WHOLE)	10	

2: **Q1**

Indicate Program

01	NH:PA	1
02	NH	2
03	SIP	3
04	Ventures	4
05	NACA	5
06	SIRP	6
07	Internal Projects	7

3: **Q2A**

What is the name of the project?

01	Response	1	O

4: **Q2B**

What is the project number?

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5: **Q3**

What is the year category?

01	1991-92	1	
02	1992-93	2	
03	1993-94	3	
04	1994-95	4	
05	1995-96	5	

6: **Q4A**

What is the project's duration (in months)?

			SE
01	Information not in file	9999	

7: **Q4B**

Is the project completed or ongoing?

01	Completed	1	
02	Ongoing	2	
03	Information not in file	9	

8: **Q5**

What are the project's objectives?

01	Objective	01	O
02	Information not in file	99	

9: **Q6A**

Does the project address health and well-being?

01	Yes (definition)	01	O
02	No	02	
03	Information not in file	99	
04	MENTAL/EMOTal WELL-BEING OR SUPPORT	11	
05	PHYSICAL WELL-BEING OR HEALTH (PREVENTION)	12	
06	ABUSE - PHYSICAL	13	
07	ABUSE - EMOTIONAL	14	
08	ABUSE - DRUG AND ALCOHOL	15	
09	ABUSE - FINANCIAL	16	
10	SOCIAL ISOLATION / LONELINESS	17	
11	GEOGRAPHIC ISOLATION	18	
12	POOR NUTRITION	19	
13	DEPRESSION	20	
14	CHRONIC ILLNESS	21	
15	DEMENTIA	22	
16	DISABLED SENIORS	23	
17	SAFETY	24	

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10: **Q6B**

Does the project address seniors independence?

01	Yes (definition)	01	○
02	No	02	
03	Information not in file	99	
04	TRANSPORTATION SRVs	11	
05	INFO ON PRGs & SRVs	12	
06	MEALS BROUGHT TO HOME	13	
07	CONGREGATE MEALS	14	
08	HOME VISITS/IN-HOME SUPPORTS	15	
09	MISC. ALLOW SRs TO REMAIN HOME/INDEP.	16	
10	ASSIST DISABLED SRs (BLIND, MOBILITY)	17	
11	IMPROVES LITERACY	18	
12	EDUC (FIANC, HEALTH, CDN CULT. COOKING etc.)	19	
13	SUPPORT (PEER, VOLUNts)	20	
14	ACTIVs IN COMMUN. TO ENCOURAGE INDEP.	21	
15	HOUSING	22	
16	SECURITY/SAFETY	23	
17	OTH ("DYING w/DIGNITY", SELF FUNDING, INCM SECUR.)	24	

11: **Q6C**

Does the project address attitudes towards aging?

01	Yes	1
02	No	2
03	Information not in file	9

12: **Q6D**

Does the project address barriers to seniors involvement/participation in society?

01	Yes (definition)	01	○
02	No	02	
03	Information not in file	99	
04	LANG. BARRIER	11	
05	TRANSPORTATION	12	
06	PROVIDE PLACE & OPPORT. SRs CAN MEET	13	
07	ACTs ENCOURAGE PARTICIPATION	14	
08	ADDRESS BARRIERS FOR DISABLED/ILLITERATE SRs	15	
09	TARGET ISOLATED SRs TO ACTIVE	16	
10	INFO/EDUC TO SRs ABOUT SRVs	17	
11	OTHERS	18	

13: **Q6E**

Are there other needs that this project is addressing?

01	Yes (need)	01	○
02	No	02	
03	Information not in file	99	

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14: **Q7A**

Does this project target seniors in general?

01	Yes	1
02	No	2
03	Information not in file	9

15: **Q7B**

Does this project target seniors at risk?

01	Yes (risk)	01	O
02	No	02	
03	Information not in file	99	
04	RURAL/REMOTE	11	
05	WOMEN	12	
06	SOCIALLY ISOLATED	13	
07	LOW INCOME	14	
08	LOW LITERACY	15	
09	DEMENTIA/MENTALLY ILL	16	
10	VERY OLD SRs(FRAIL)	17	
11	DISABLE/HOME BOUND	18	
12	ABUSED/RISK OF ABUSED	19	
13	LANG. BARRIER	20	
14	ETHNIC MINORITIES	21	
15	NATIVE/ABORIGINAL	22	
16	CHRONICALLY/RECUR HEALTH PROBs	23	

16: **Q7C**

Does this project target any other group?

01	Yes (group)	01	O
02	No	02	
03	Information not in file	99	

17: **Q8A**

Are the clients of this project seniors in general?

01	Yes	1
02	No	2
03	Information not in file	9

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18: Q8B

Are the clients of this project seniors at risk?

01	Yes (risk)	01	○
02	No	02	
03	Information not in file	99	
04	RURAL/REMOTE	11	
05	WOMEN	12	
06	SOCIALLY ISOLATED	13	
07	LOW INCOME	14	
08	LOW LITERACY	15	
09	DEMENTIA/MENTALLY ILL	16	
10	VERY OLD SRs(FRAIL)	17	
11	DISABLE/HOME BOUND	18	
12	ABUSED/RISK OF ABUSED	19	
13	LANG. BARRIER	20	
14	ETHNIC MINORITIES	21	
15	NATIVE/ABORIGINAL	22	
16	CHRONICALLY/RECUR HEALTH PROBs	23	

19: Q8C

Are the clients of this project other groups of seniors?

01	Yes (group)	01	○
02	No	02	
03	Information not in file	99	
04	SRs ORGANIZATION	11	
05	VOLUNTEERS	12	
06	CAREGIVERS	13	

20: Q8D

Are any of the following groups clients of this project?

01	No	01	
02	Minister of Health	02	
03	Minister Responsible for Seniors	03	
04	Federal government	04	
05	Other government departments	05	
06	Provinces/territories	06	
07	Independent researchers	07	
08	Universities	08	
09	Centres of Gerontology	09	
10	NGOs: national	10	
11	NGOs: regional	11	
12	NGOs: local	12	
13	NGOs: Public/consumers	13	
14	Private sector	14	
15	International clients	15	
16	Other (specify)	16	○
17	Information not in file	99	

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21: **Q9**

What are this project's activities?

01	Providing services to seniors	01	
02	Research	02	
03	Conferences	03	
04	Workshops	04	
05	Monitoring of senior's health problems	05	
06	Dissemination of information	06	
07	Policy development	07	
08	Communications	08	
09	Coordinates seniors initiatives: federal level/interdepartmental	09	
10	Coordinates seniors initiatives: provincial or territorial level	10	
11	Coordinates seniors initiatives: local level	11	
12	Coordinates seniors initiatives: interdepartmental	12	
13	Coordinates seniors initiatives: NGOs	13	
14	Coordinates seniors initiatives: private sector	14	
15	Public education campaigns	15	
16	Knowledge development	16	
17	Funding of community projects	17	
18	Funding of research programs	18	
19	Consultation with seniors or other stakeholders	19	
20	Education to professionals	20	
21	Increasing awareness of seniors issues	21	
22	Partnership development	22	
23	Other (specify)	23	○

22: **Q10A**

Has this project contributed to developing an innovative approach by introducing a new approach?

01	Yes (approach)	01	○
02	No	02	
03	Information not in file	99	

23: **Q10B**

Has this project contributed to developing an innovative approach by addressing a new issue?

01	Yes (issue)	01	○
02	No	02	
03	Information not in file	99	

24: **Q10C**

Has this project contributed to developing an innovative approach by targeting different groups of seniors?

01	Yes (group)	01	○
02	No	02	
03	Information not in file	99	

25: **Q10D**

Has this project contributed to developing an innovative approach by taking place in a different milieu (e.g., rural/urban)?

01	Yes (milieu)	01	○
02	No	02	
03	Information not in file	99	

26: **Q10E**

Has the project contributed to developing innovative approaches by bringing together different stakeholders?

01	Yes (stakeholders)	01	○
02	No	02	
03	Information not in file	99	

27: **Q10F**

Has the project contributed to developing innovative approaches by developing and synthesizing new knowledge?

01	Yes (knowledge)	01	○
02	No	02	
03	Information not in file	99	

28: **Q10G**

Has this project contributed to developing an innovative approach in any other way?

01	Yes (method)	01	○
02	No	02	
03	Information not in file	99	

29: **Q11**

Has this project required any financial resources?

01	Yes	1	
02	No	2	=> Q11C
03	Information not in file	9	=> Q11C

```
What financial resources has this project required?

          DAS/S:      @q11a
          Partners:   @q11b
Your organization:    @q11aa
          Others:     @q11bb

         Round to the nearest dollar.  Do not put in commas.
         If the information is not provided in the file - 99999999
         If NA - leave blank
```

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30: **Q11A**
DAS/S

31: **Q11B**
Partners

32: **Q11AA**
Your Organization

33: **Q11BB**
Others

34: **Q11C**
Were there any in-kind contributions?

01	Yes	1	
02	No	2	=> Q11D
03	Information not in file	9	=> Q11D

```
Were there any in-kind contributions and, if possible, what was their value?

 Contrib 1: @q11ca                                 Value 1: @q11c1
 Contrib 2: @q11cb                                 Value 2: @q11c2
 Contrib 3: @q11cc                                 Value 3: @q11c3
 Contrib 4: @q11cd                                 Value 4: @q11c4
 Contrib 5: @q11ce                                 Value 5: @q11c5
 Other: @q11cf                                     Value: @q11co

                              Round to the nearest dollar.  Do not use commas.
```

35: **Q11CA**
Contribution 1

36: **Q11C1**
Value 1

SE

37: **Q11CB**
Contribution 2

38: **Q11C2**
Value 2

SE

39: **Q11CC**
Contribution 3

40: **Q11C3**
Value 3

SE

41: **Q11CD**
Contribution 4

42: **Q11C4**
Value 4

SE

43: **Q11CE**
Contribution 5

44: **Q11C5**
Value 5

SE

45: **Q11CF**
Contribution - other

46: **Q11CO**
Value- other

SE

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47: **Q11D**

How many volunteers assist with this project's activities?

SE

01	None	000	=> Q12
02	N/A	998	=> Q12
03	Information not in file	999	=> Q12

48: **Q11E1**

How much time (in hours) has been spent by volunteers (in total) during the duration of this project?

SE

01	Information not in file	9999

49: **Q12**

If a funded project, will the project be self-sufficient once funding ends?

01	Yes	1	
02	No	2	=> Q12F
03	Information not in file	9	=> Q12F

```
Where will funding come from and, if possible, what will be the amount?

 Source 1: @q12a                              Value 1: @q12a1
 Source 2: @q12b                              Value 2: @q12b1
 Source 3: @q12c                              Value 3: @q12c1
 Source 4: @q12d                              Value 4: @q12d1
 Source 5: @q12e                              Value 5: @q12e1
 Other: @q12o                                 Other: @q12o1

                               Round to the nearest dollar.  Do not use commas.
```

50: **Q12A**

Source 1

51: **Q12A1**

Value 1

SE

52: **Q12B**

Source 2

53: **Q12B1**
Value 2

SE

54: **Q12C**
Source 3

55: **Q12C1**
Value 3

SE

56: **Q12D**
Source 4

57: **Q12D1**
Value 4

SE

58: **Q12E**
Source 5

59: **Q12E1**
Value 5

SE

60: **Q12O**
Source - other

61: **Q12O1**
Value - other

SE

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62: Q12F

If the project does not have self-sufficiency as a goal, has this project led to continuing activities?

01	Yes (activity)	01	O
02	No	02	
03	N/A	98	
04	Information not in file	99	

63: PRE13

Have you developed partnerships with other groups/organizations/agencies?

01	Yes	1	
02	No partnerships developed	2	=> PRE14
03	N/A	3	=> PRE14
04	Information not in file	9	=> PRE14

64: Q13A

In what capacity has partnership with the FEDERAL GOVERNMENT been developed?

01	No partnership has been developed	01	
02	This is a new partnership	02	
03	Joint-decision making	03	
04	Advisory body	04	
05	Shared facilities	05	
06	Financial contributions - in addition to the funding provided by DAS/S	06	
07	In-Kind contributions	07	
08	Materials	08	
09	Human Resources	09	
10	Other (specify)	10	O
11	Information not in file	99	

65: Q13B

In what capacity has partnership with the PROVINCIAL/TERRITORIAL GOVERNMENT been developed?

01	No partnership has been developed	01	
02	This is a new partnership	02	
03	Joint-decision making	03	
04	Advisory body	04	
05	Shared facilities	05	
06	Financial contributions - in addition to the funding provided by DAS/S	06	
07	In-Kind contributions	07	
08	Materials	08	
09	Human Resources	09	
10	Other (specify)	10	O
11	Information not in file	99	

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66: **Q13C**

In what capacity has partnership with NGOs: NATIONAL been developed?

01	No partnership has been developed	01	
02	This is a new partnership	02	
03	Joint-decision making	03	
04	Advisory body	04	
05	Shared facilities	05	
06	Financial contributions - in addition to the funding provided by DAS/S	06	
07	In-Kind contributions	07	
08	Materials	08	
09	Human Resources	09	
10	Other (specify)	10	○
11	Information not in file	99	

67: **Q13D**

In what capacity has partnership with NGOs: REGIONAL been developed?

01	No partnership has been developed	01	
02	This is a new partnership	02	
03	Joint-decision making	03	
04	Advisory body	04	
05	Shared facilities	05	
06	Financial contributions - in addition to the funding provided by DAS/S	06	
07	In-Kind contributions	07	
08	Materials	08	
09	Human Resources	09	
10	Other (specify)	10	○
11	Information not in file	99	

68: **Q13E**

In what capacity has partnership with NGOs: LOCAL been developed?

01	No partnership has been developed	01	
02	This is a new partnership	02	
03	Joint-decision making	03	
04	Advisory body	04	
05	Shared facilities	05	
06	Financial contributions - in addition to the funding provided by DAS/S	06	
07	In-Kind contributions	07	
08	Materials	08	
09	Human Resources	09	
10	Other (specify)	10	○
11	Information not in file	99	

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69: **Q13F**

In what capacity has partnership with SENIORS ORGANIZATIONS been developed?

01	No partnership has been developed	01	
02	This is a new partnership	02	
03	Joint-decision making	03	
04	Advisory body	04	
05	Shared facilities	05	
06	Financial contributions - in addition to the funding provided by DAS/S	06	
07	In-Kind contributions	07	
08	Materials	08	
09	Human Resources	09	
10	Other (specify)	10	○
11	Information not in file	99	

70: **Q13G**

In what capacity has partnership with UNIVERSITIES been developed?

01	No partnership has been developed	01	
02	This is a new partnership	02	
03	Joint-decision making	03	
04	Advisory body	04	
05	Shared facilities	05	
06	Financial contributions - in addition to the funding provided by DAS/S	06	
07	In-Kind contributions	07	
08	Materials	08	
09	Human Resources	09	
10	Other (specify)	10	○
11	Information not in file	99	

71: **Q13H**

In what capacity has partnership with CENTRES OF GERONTOLOGY been developed?

01	No partnership has been developed	01	
02	This is a new partnership	02	
03	Joint-decision making	03	
04	Advisory body	04	
05	Shared facilities	05	
06	Financial contributions - in addition to the funding provided by DAS/S	06	
07	In-Kind contributions	07	
08	Materials	08	
09	Human Resources	09	
10	Other (specify)	10	○
11	Information not in file	99	

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72: **Q13I**

In what capacity has partnership with INDEPENDENT RESEARCHERS been developed?

01	No partnership has been developed	01	
02	This is a new partnership	02	
03	Joint-decision making	03	
04	Advisory body	04	
05	Shared facilities	05	
06	Financial contributions - in addition to the funding provided by DAS/S	06	
07	In-Kind contributions	07	
08	Materials	08	
09	Human Resources	09	
10	Other (specify)	10	O
11	Information not in file	99	

73: **Q13J**

In what capacity has partnership with BUSINESS been developed?

01	No partnership has been developed	01	
02	This is a new partnership	02	
03	Joint-decision making	03	
04	Advisory body	04	
05	Shared facilities	05	
06	Financial contributions - in addition to the funding provided by DAS/S	06	
07	In-Kind contributions	07	
08	Materials	08	
09	Human Resources	09	
10	Other (specify)	10	O
11	Information not in file	99	

74: **Q13K**

If a partnership has been developed with OTHER GROUPS, in what capacity has partnership with the first group been developed?

01	No other partnership has been developed	01		=> PRE14
02	This is a new partnership	02		
03	Joint-decision making	03		
04	Advisory body	04		
05	Shared facilities	05		
06	Financial contributions	06		
07	In-Kind contributions	07		
08	Materials	08		
09	Human Resources	09		
10	Other (specify)	10	O	
11	Information not in file	99		

75: **Q13K1**

Specify the name of the first group

01	Response	01	O

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76: **Q13L**

In what capacity has partnership with a second group been developed?

01	No other partnership has been developed	01		=> PRE14
02	This is a new partnership	02		
03	Joint-decision making	03		
04	Advisory body	04		
05	Shared facilities	05		
06	Financial contributions	06		
07	In-Kind contributions	07		
08	Materials	08		
09	Human Resources	09		
10	Other (specify)	10	O	
11	Information not in file	99		

77: **Q13L1**

Specify the name of the second group

01	Response	01	O

78: **Q13M**

In what capacity has partnership with a third group been developed?

01	No other partnership has been developed	01		=> PRE14
02	This is a new partnership	02		
03	Joint-decision making	03		
04	Advisory body	04		
05	Shared facilities	05		
06	Financial contributions	06		
07	In-Kind contributions	07		
08	Materials	08		
09	Human Resources	09		
10	Other (specify)	10	O	
11	Information not in file	99		

79: **Q13M1**

Specify the name of the third group

01	Response	01	O

80: **PRE14**

Have there been any outputs or results?

01	Yes	1	
02	No	2	=> Q14B
03	N/A	3	=> Q14B
04	Information not in file	9	=> Q14B

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81: **Q14A1**

Have services been provided to seniors?

01	Yes (service)	01	O
02	No	02	
03	Information not in file	99	
04	MEALS	11	
05	SOCIAL ACTs(GAMES,FIELD TRIPS)	12	
06	EDUC. ACTs(SPEAKER,CLASS)	13	
07	CRAFT ACTs	14	
08	VISITS	15	
09	HEALTH ACTs(FITNESS CLASS)	16	
10	HEALTH VISITS(FOOT CLINIC,COUNSELLING)	17	
11	TRANSPORTATION	18	
12	TRAINING	19	

82: **Q14A2**

How many publications have been published?

SE

01	None	000
02	Information not in file	999

83: **Q14A3**

How many research reports have been produced.

SE

01	None	000
02	Information not in file	999

84: **Q14A4**

Have there been any policies developed?

01	Yes	1
02	No	2
03	Information not in file	9

85: **Q14A5**

Have there been any workshops?

01	Yes	1
02	No	2
03	Information not in file	9

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86: **Q14A6**

Have there been any roundtables?

01	Yes	1
02	No	2
03	Information not in file	9

87: **Q14A7**

Have educational materials been produced?

01	Yes	1
02	No	2
03	Information not in file	9

88: **Q14A8**

Has advice to program or policies been provided?

01	Yes	1
02	No	2
03	Information not in file	9

89: **Q14A9**

Has advice to the Minister been provided?

01	Yes	1
02	No	2
03	Information not in file	9

90: **Q14AO**

Have there been any other outputs or products?

01	Yes (output)	01	O
02	No	02	
03	Information not in file	99	
04	IMPLEMENTATION OUTPUTS	11	
05	BROCHURE/POSTER	12	
06	VIDEO	13	
07	TRAINING	14	
08	MEDIA	15	
09	CONFERENCE/PRESENTATION	16	
10	DEVELOP SUPPORT NETWORK	17	

91: **Q14B**

How many new projects have been created due to the activities of this current project?

			SE
01	None	00	=> Q14C
02	N/A	98	=> Q14C
03	Information not in file	99	=> Q14C

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92: **Q14B1**

What types of new projects have been created?

01	Yes (type)	01	O
02	Information not in file	99	

93: **Q14C**

How many clients in total have been served?

$E

01	None	000
02	N/A	998
03	Information not in file	999

94: **Q14D**

How many seniors have been served?

$E

01	None	000
02	N/A	998
03	Information not in file	999

95: **Q15A**

Has an evaluation of this project been completed?

01	Yes	1	
02	No	2	=> Q16A

96: **Q15B**

What is the quality of this evaluation?

01	Very poor	1	
02	Poor	2	
03	Fair	3	
04	Good	4	
05	Very good	5	
06	Information not in file	9	=> Q16A

97: **Q15C**

Why did you give the quality of the project evaluation the rating that you did in Q15B?

01	Specify	01	O

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98: **Q16A**

What have been the impacts and effects to date?

01	Impacts	001	O	
02	No impacts or effects	002		
03	Information not in file	999		

99: **Q16B**

Have there been any unplanned effects - either positive or negative (e.g., overlap with similar projects, complaints by provincial/territorial governments)?

01	Effects	001	O	
02	No	002		
03	Information not in file	999		

100: **Q17A**

What are the strengths of this project (specify only if noted in the file information)?

01	Strengths	01	O	
02	No strengths noted in the file	02		

101: **Q17B**

What are the weaknesses of this project (specify only if noted in the file information)?

01	Weaknesses	01	O	
02	No weaknesses noted in the file	02		

102: **DONE**

Is there any additional/outstanding information yet to be entered?

01	Yes	1	D	
02	No	2		
03	DK/NR	9		

103: **INT**

Do you want to close this file for good or do you want the opportunity to come back to it?

01	Close it for good	1		=> SURE
02	File it away for re-entry later	2		=> CB

104: **SURE**

Are you sure you want this case for good? IT WILL NOT BE RETRIEVABLE AFTERWARDS!

01	Yes	1		=> END
02	No	2	D	=> INT

105: **CB**

Are you sure you want to store this file in your "call-backs" for further references?

```
01   Yes ........................................................ 1     D     => END
02   No ......................................................... 2           => INT
```

106: **TOEND**

=> END if 0==0

107: **DUM_1**

=> END if 0==0

108: **DUM_2**

109: **DUM_5**

=> Q11C if 0==0

110: **DUM_8**

111: **DUM_9**

112: **DUM10**

APPENDIX D
Interview Guides

INTERVIEW GUIDE

Health Canada Personnel

Ekos Research Associates Inc. has been commissioned by Health Canada to conduct an evaluation of the success and continued relevance of the Division of Aging and Seniors/Seniors Strategy (DAS/S) as well as to identify possible alternatives to the strategy[1]. The Division of Aging and Seniors/Seniors Strategy is comprised of four program elements: 1) Seniors Community Programs Funding (i.e., New Horizons: Partners in Aging, and the former Seniors Independence Program, Ventures in Independence and New Horizons programs); 2) Seniors Independence Research Program; 3) Policy Coordination and Support to the Minister; and 4) National Advisory Council on Aging (NACA). Former and present Health Canada organizational units covered by the strategy include: the Seniors Secretariat; NACA Secretariat; Seniors Community Programs; Aging-Related Diseases Division; Health Policy; the National Health Research and Development Program (Seniors Independence Research Program component); Seniors Directorate; and Regional Offices.

The purpose of this interview is to obtain views on the impacts and overall relevance of the Division of Aging and Seniors/Seniors Strategy. The respondent should feel free to tell the interviewer if he/she does not feel confident enough to answer specific questions.

I. Program Relevance

1. In your opinion, what are the most important needs of today's seniors? On what do you base your opinion?

    ❑ Is there a relevant role for the federal government to take in addressing these needs? Is there a role for Health Canada? Please explain.

    ❑ Does the Division of Aging and Seniors/Seniors Strategy have a role to play in addressing these needs? In what way?

2. Is there a continuing role for the Division of Aging and Seniors/Seniors Strategy to play in:

    ❑ improving and preserving the *health and well-being* of Canadian seniors? What should be this role? On what do you base your opinion?

    ❑ improving and preserving the *independence* (living arrangements, transportation, social support networks) of Canadian seniors? What should be this role? On what do you base your opinion?

    ❑ increasing society's *understanding and acceptance of seniors*? What should be this role? On what do you base your opinion?

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- ☐ *eliminating barriers to the involvement and participation of seniors in society?* What should be this role? On what do you base your opinion?

3. Do the activities under the Division of Aging and Seniors/Seniors Strategy *supplement or complement* the activities of other federal or provincial/territorial departments or NGOs, or do they *overlap*? If they overlap, in what way?

II. Program Accomplishments

4. Has the Division of Aging and Seniors/Seniors Strategy *increased and consolidated knowledge on aging and seniors*? If yes, how? If no, why not?

   - ☐ To what extent is this knowledge being shared with, disseminated to other stakeholders and other federal and provincial/territorial departments? If yes, how? If no, why not?

   - ☐ Have the research and knowledge development activities supported and/or undertaken by the Division of Aging and Seniors/Seniors Strategy met seniors's needs? How?

5. Has the Division of Aging and Seniors/Seniors Strategy provided seniors with the *information they need and the opportunity to make informed choices* on issues that affect their health, well-being and independence? On what do you base your opinion?

6. Have networks between seniors and other sectors of society been developed through the Division of Aging and Seniors/Seniors Strategy? Have networks of researchers been developed? On what do you base your opinion?

7. To what extent has the Division of Aging and Seniors/Seniors Strategy *developed and promoted integrated policies and strategies* that address the needs of seniors for government and non-government organizations? On what do you base your opinion?

   - ☐ What expertise has been provided to deliberations on policy/program development from the Division of Aging and Seniors/Seniors Strategy? Has this been useful? If yes, how? If no, why not?

8. To what extent has the Division of Aging and Seniors/Seniors Strategy *promoted a positive and realistic image of seniors*? On what do you base your opinion?

9. To what extent has the Division of Aging and Seniors/Seniors Strategy *provided the National Advisory Council on Aging with the support it requires to fulfil its mandate*? On what do you base your opinion?

10. To what extent have projects funded by the Division of Aging and Seniors/ Seniors Strategy been innovative?

11. How would you describe the level of coordination for seniors/aging issues within Health Canada and with other federal departments? Is the coordination as effective as it should be?

12. Have partnerships been developed as a result of Health Canada's activities in the Division of Aging and Seniors/Seniors Strategy?

    ☐ Partnershps between Health Canada and other levels of government? The private sector? Non-government organizations?

    ☐ Have partnerships been developed among these groups?

13. To what extent have changes to the Division of Aging and Seniors/Seniors Strategy (e.g., changes in resources, programs, organizational structure) influenced program delivery or the achievement of its objectives? Please specify which changes/factors have had an influence and how.

14. Are there any *unintended* effects (positive or negative) of the Division of Aging and Seniors/Seniors Strategy? Specify.

15. What are the overall strengths and weaknesses of the Division of Aging and Seniors/Seniors Strategy?

    ☐ Which types of programs/activities have been most beneficial to seniors' health, well-being and independence? Which have been least beneficial?

III. Alternatives

16. Given the involvement of other federal government departments, provincial/ territorial governments and non-government organizations, do you feel Health Canada should continue to maintain all of its activities under the Division of Aging and Seniors/Seniors Strategy?

    ☐ Could the responsibilities for some of these programs and activities be handed over to other federal departments, provincial/territorial governments, local governments or NGOs? Which ones and how?

    ☐ Do you have any ideas for new mechanisms or structures:

    - To meet seniors' needs in general?
    - To improve the health, well-being and independence of seniors?

- ☐ How do the activities/functions of the Division of Aging and Seniors/Seniors Strategy fit into the Population Health Strategy?

- ☐ Which activities and expertise in seniors/aging issues currently supported by the Division of Aging and Seniors/Seniors Strategy should Health Canada definitely retain?

  - In what order of priority would you place these activities?

- ☐ Which types of programs/activities currently supported by the Division of Aging and Seniors/Seniors Strategy do you feel have been the most cost-effective? Explain.

- ☐ Which types of programs/activities have been less cost-effective? Explain.

IV. Further Questions (Only if Time Allows)

17. In your opinion, what groups can be considered as "at-risk" seniors? On what do you base your opinion?

    - ☐ Does the Division of Aging and Seniors/Seniors Strategy have a role to play in addressing their needs? In what way?

18. Do you feel the Division of Aging and Seniors/Seniors Strategy reaches all major segments/types of seniors "at risk"? If yes, how? If no, why not? Which types of "at risk" seniors are not being reached?

19. To what extent is the Division of Aging and Seniors/Seniors Strategy meeting the most important needs of seniors, including seniors "at risk"? On what do you base your opinion?

20. Would the health, well-being and independence of Canada's seniors have been affected if there had been no Division of Aging and Seniors/Seniors Strategy? If yes, how? If no, why not?

    - ☐ Thinking of the future, would the health, well-being and independence of Canada's seniors be affected if there were no Division of Aging and Seniors/Seniors Strategy and, more generally, no Health Canada programming for seniors? Please explain.

21. Do you have any other comments?

THANK YOU FOR YOUR PARTICIPATION

INTERVIEW GUIDE

Funding Recipients

Ekos Research Associates Inc. has been commissioned by Health Canada to conduct an evaluation of the success and continued relevance of the Department's programs for seniors as well as to identify possible alternative approaches[1]. The programs for seniors include: 1) Seniors Community Programs Funding (i.e., New Horizons: Partners in Aging, and the former Seniors Independence Program, Ventures in Independence and New Horizons programs); 2) Seniors Independence Research Program; 3) Policy Coordination and Support to the Minister; and 4) National Advisory Council on Aging (NACA). Collectively, these programs are formally called the Division of Aging and Seniors/Seniors Strategy. Former and present Health Canada organizational units involved in these programs include: the Seniors Secretariat; NACA Secretariat; Seniors Community Programs; Aging-Related Diseases Division; Health Policy; the National Health Research and Development Program (Seniors Independence Research Program component); Seniors Directorate; and Regional Offices.

The purpose of this interview is to obtain views on the impacts and overall relevance of Health Canada's programs for seniors. The respondent should feel free to tell the interviewer if he/she does not feel confident enough to answer specific questions. Answers to the interview questions will not influence in any way current or future funding from Health Canada.

I. Background Information

1. Our files indicate that you applied to the [PROGRAM NAME] in [YEAR] for funding for [PROJECT NAME]. Is that correct?

   ☐ Did you receive funding from the [PROGRAM NAME]?

   - If no, end interview.

2. What are/were the objectives of your organization/project?

3. How did you become involved with the [PROGRAM NAME]?

   ☐ Have you received any other funding from Health Canada with respect to seniors/aging projects? Specify.

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II. Program Relevance

4. Are you familiar with the objectives of the program that funded your project?

5. How satisfied are/were you with the administrative processes and delivery of the program that funded your project? (focus attention on processes, delivery and actual level of funding)

   ☐ level and type of funding
   ☐ administrative requirements
   ☐ technical support

6. Has the project in which you are/were involved:

   ☐ contributed to developing innovative approaches which have been replicated elsewhere to improve social and/or health services?
   ☐ addressed new issues?
   ☐ developed and disseminated knowledge?
   ☐ targeted different groups of seniors?
   ☐ taken place in different milieus (e.g., rural/urban)?

7. Will the activities of your project continue after the Health Canada funding ends?

   ☐ Was this the intention for your project?

   ☐ Has the project been (or will it be) able to obtain funding from other sources after the federal funding ceased? From what source?

   ☐ Were there any spin-off projects intended? Did any spin-offs result?

8. Does your project *supplement or complement* the activities of other federal or provincial/territorial departments or non-government organizations, or do they *overlap*? If they overlap, in what way?

III. Program Accomplishments

9. Has your project met its objectives? On what do you base your opinion?

10. What are/have been the impacts and effects of your project on:

   ☐ Individual Canadian seniors?
   ☐ Health and other professionals working with seniors?
   ☐ Government policies and programs?
   ☐ The work of other organizations?

- ☐ At the national, provincial and/or local level?

11. To what extent is your project cost-effective?

12. Have partnerships been developed as a result of Health Canada's program funding?

    - ☐ Partnerships between Health Canada and other levels of government? The private sector? Non-government organizations?

    - ☐ Have partnerships been developed among these groups?

    - ☐ What types of partnerships:

        - financial partnerships?
        - ongoing working relationships?
        - shared policy reviews?
        - other?

13. Would your activities have taken place without the funding from the Health Canada [PROGRAM NAME]?

14. Are there any *unintended* effects (positive or negative) of your project? Specify.

15. In your opinion, what are the overall strengths and weaknesses of:

    - ☐ Your project?
    - ☐ The program that funded your project?

IV. Alternatives

16. Given the involvement of other federal government departments, provincial/territorial governments and non-government organizations, do you feel Health Canada should continue to maintain all of the activities/programs funded under its programs for seniors?

    - ☐ Could the responsibilities for some of these programs and activities be handed over to other federal departments, provincial/territorial governments, local governments or NGOs? Which ones and how?

    - ☐ Could some activities/programs be eliminated entirely? Which ones?

    - ☐ Do you have any ideas for new mechanisms or structures:

        - To meet seniors' needs in general?
        - To improve the health, well-being and independence of seniors?

☐ Which activities and expertise in seniors/aging issues should the federal government definitely retain?

- Is Health Canada the most appropriate department to deliver these programs/activities?
- Which activities should Health Canada definitely retain?
- In what order of priority would you place these activities?

☐ Which types of programs/activities currently supported by Health Canada do you feel have been the most cost-effective? Explain.

☐ Which types of programs/activities have been less cost-effective? Explain.

IV. Further Questions (Only if Time Allows)

17. In your opinion, what groups can be considered as "at-risk" seniors? On what do you base your opinion?

☐ What are their most important needs?

☐ Does your project have a role to play in addressing their needs? In what way?

18. Do you feel your project reaches some major segments/types of seniors "at risk"? If yes, how? If no, why not?

19. To what extent is your project meeting some of the important needs of seniors, including seniors "at risk"? On what do you base your opinion?

20. Do you have any other comments?

THANK YOU FOR YOUR PARTICIPATION

INTERVIEW GUIDE

Central Agencies

Ekos Research Associates Inc. has been commissioned by Health Canada to conduct an evaluation of the success and continued relevance of the Division of Aging and Seniors/Seniors Strategy (DAS/S) as well as to identify possible alternatives to the strategy[1]. The Division of Aging and Seniors/Seniors Strategy is comprised of four program elements: 1) Seniors Community Programs Funding (i.e., New Horizons: Partners in Aging, and the former Seniors Independence Program, Ventures in Independence and New Horizons programs); 2) Seniors Independence Research Program; 3) Policy Coordination and Support to the Minister; and 4) National Advisory Council on Aging (NACA). Former and present Health Canada organizational units covered by the strategy include: the Seniors Secretariat; NACA Secretariat; Seniors Community Programs; Aging-Related Diseases Division; Health Policy; the National Health Research and Development Program (Seniors Independence Research Program component); Seniors Directorate; and Regional Offices.

The purpose of this interview is to obtain views on the impacts and overall relevance of the Division of Aging and Seniors/Seniors Strategy. The respondent should feel free to tell the interviewer if he/she does not feel confident enough to answer specific questions.

I. Program Relevance

1. How important do you feel it is for the federal government to be involved in trying to:

   ☐ improve and preserve the health, well-being and independence of Canadian seniors;

   ☐ increase society's understanding and acceptance of seniors; and

   ☐ eliminate barriers to the involvement and participation of seniors in society.

2. Is there a continuing role for Health Canada in any of these activities? What should its priorities be?

3. Are there other areas concerning seniors and/or the aging population in which Health Canada should be more involved (priority needs, special groups)?

4. Do you feel that Health Canada's role of coordinating the Division of Aging and Seniors/Seniors Strategy and administering the majority of its programs is a good/appropriate role for it to be playing?

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- ❑ How well do you feel it has carried out this role — at the interdepartmental level and within Health Canada?
- ❑ Is the role of the Division of Aging and Seniors/Seniors Strategy as the coordinating/focal point for seniors/aging issues within the federal government appropriate?

II. Program Accomplishments

5. To what extent do you feel the Division of Aging and Seniors/Seniors Strategy is meeting its objectives:

    - ❑ to increase and consolidate knowledge on aging and seniors issues and to share this knowledge with other federal government departments, the provinces and stakeholders?
    - ❑ to guide the development of programs, policies and strategies that are innovative, effective and address the needs of seniors and an aging society?
        - To what extent has the Division of Aging and Seniors/Seniors Strategy influenced the policies and programs of other federal departments, other levels of government and non-government organizations?
    - ❑ to promote a positive and realistic image of seniors to Canadian society through the Division's activities, communications and educational initiatives?
    - ❑ to provide seniors with the information they need as well as the opportunity to make informed choices on issues that affect their health, well-being and independence?
    - ❑ to provide the National Advisory Council on Aging with the support it requires to fulfil its mandate?

6. What impact do you believe government cuts have had or would have on the capacity of the Division of Aging and Seniors/Seniors Strategy to meet its objectives?

7. What are the strengths and weaknesses of the Division of Aging and Seniors/Seniors Strategy overall?

III. Alternatives

8. Given the involvement of other federal government departments, provincial/ territorial governments and non-government organizations, do you feel Health Canada should continue to maintain all of its activities under the Division of Aging and Seniors/Seniors Strategy?

   - ☐ Could the responsibilities for some of these programs and activities be handed over to other federal departments, provincial/territorial governments, local governments or NGOs? Which ones and how?
   - ☐ Do you have any ideas for new mechanisms or structures:
     - To meet seniors' needs in general?
     - To improve the health, well-being and independence of seniors?
   - ☐ How do the activities/functions of the Division of Aging and Seniors/ Seniors Strategy fit into the Population Health Strategy?
   - ☐ Which activities and expertise in seniors/aging issues currently supported by the Division of Aging and Seniors/Seniors Strategy should Health Canada definitely retain?
     - In what order of priority would you place these activities?
   - ☐ Which types of programs/activities currently supported by the Division of Aging and Seniors/Seniors Strategy do you feel have been the most cost-effective? Explain.
   - ☐ Which types of programs/activities have been less cost-effective? Explain.

9. Do you have any other comments?

THANK YOU FOR YOUR PARTICIPATION

INTERVIEW GUIDE

Provincial/Territorial Government Officials and IDCSI

Ekos Research Associates Inc. has been commissioned by Health Canada to conduct an evaluation of the success and continued relevance of the Division of Aging and Seniors/Seniors Strategy (DAS/S) as well as to identify possible alternatives to the strategy[1]. The Division of Aging and Seniors/Seniors Strategy is comprised of four program elements: 1) Seniors Community Programs Funding (i.e., New Horizons: Partners in Aging, and the former Seniors Independence Program, Ventures in Independence and New Horizons programs); 2) Seniors Independence Research Program; 3) Policy Coordination and Support to the Minister; and 4) National Advisory Council on Aging (NACA). The strategy also supports the Federal/ Provincial/Territorial Committee of Officials and Ministers Responsible for Seniors. Former and present Health Canada organizational units covered by the strategy include: the Seniors Secretariat; NACA Secretariat; Seniors Community Programs; Aging-Related Diseases Division; Health Policy; the National Health Research and Development Program (Seniors Independence Research Program component); Seniors Directorate; and Regional Offices.

The purpose of this interview is to obtain views on the impacts and overall relevance of the Division of Aging and Seniors/Seniors Strategy. The respondent should feel free to tell the interviewer if he/she does not feel confident enough to answer specific questions.

I. Program Relevance

1. Are you familiar with the objectives of the Division of Aging and Seniors/ Seniors Strategy and its programs?

2. In your opinion, what are the most important needs of today's seniors? On what do you base your opinion?

   ☐ Is there a relevant role for the federal government to take in addressing these needs? Is there a role for Health Canada? Please explain.

   ☐ Does the Division of Aging and Seniors/Seniors Strategy have a role to play in addressing these needs? In what way?

3. Is there a continuing role for the Division of Aging and Seniors/Seniors Strategy to play in:

   ☐ improving and preserving the *health and well-being* of Canadian seniors? What should be this role? On what do you base your opinion?

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   - improving and preserving the *independence* (living arrangements, transportation, social support networks) of Canadian seniors? What should be this role? On what do you base your opinion?

   - increasing society's *understanding and acceptance of seniors*? What should be this role? On what do you base your opinion?

   - *eliminating barriers to the involvement and participation of seniors in society*? What should be this role? On what do you base your opinion?

4. Is there a coordination role for seniors/aging initiatives within the federal government? If yes, what should be the priority areas for this federal role?

5. Is there a similar initiative aimed at seniors in your department or province/territory? What is its objective and who is involved?

6. Has your approach changed due to Health Canada's activities under the Division of Aging and Seniors/Seniors Strategy? If so, how has your approach changed?

7. Have the activities of other stakeholders (e.g., non-governmental organizations) changed due to Health Canada's activities under the Division of Aging and Seniors/Seniors Strategy?

   - Have the changes been positive or negative? Examples?

8. Do the activities under the Division of Aging and Seniors/Seniors Strategy *supplement or complement* the activities of other federal or provincial/territorial departments or NGOs, or do they *overlap*? If they overlap, in what way?

II. Program Accomplishments

9. Has the Division of Aging and Seniors/Seniors Strategy *increased and consolidated knowledge on aging and seniors*? If yes, how? If no, why not?

   - To what extent is this knowledge being shared with, disseminated to other stakeholders and other federal and provincial/territorial departments? If yes, how? If no, why not?

   - Have the research and knowledge development activities supported and/or undertaken by the Division of Aging and Seniors/Seniors Strategy met seniors's needs? How?

10. Has the Division of Aging and Seniors/Seniors Strategy provided seniors with the *information they need and the opportunity to make informed choices* on issues

that affect their health, well-being and independence? On what do you base your opinion?

11. Have networks between seniors and other sectors of society been developed through the Division of Aging and Seniors/Seniors Strategy? Have networks of researchers been developed? On what do you base your opinion?

12. To what extent has the Division of Aging and Seniors/Seniors Strategy *developed and promoted integrated policies and strategies* that address the needs of seniors for government and non-government organizations? On what do you base your opinion?

    ☐ What expertise has been provided to deliberations on policy/program development from the Division of Aging and Seniors/Seniors Strategy? Has this been useful? If yes, how? If no, why not?

13. To what extent has the Division of Aging and Seniors/Seniors Strategy *promoted a positive and realistic image of seniors*? On what do you base your opinion?

14. Health Canada has been mandated to act as a coordinator between the federal government and the provinces/territories on seniors/aging issues. Do you feel that the level of coordination is appropriate?

15. Have partnerships been developed as a result of Health Canada's activities in the Division of Aging and Seniors/Seniors Strategy?

    ☐ Partnerships between Health Canada and other levels of government? The private sector? Non-government organizations?

    ☐ Have partnerships been developed among these groups?

16. What have been the impacts of federal and provincial/territorial cuts on your programming for seniors?

    ☐ What do you think will be the impact of the Canadian Health and Social Transfer (CHST) on your programming for seniors?

17. Are there any *unintended* effects (positive or negative) of the Division of Aging and Seniors/Seniors Strategy? Specify.

18. What are the overall strengths and weaknesses of the Division of Aging and Seniors/Seniors Strategy and its programs/activities and staff resources?

    ☐ Which types of programs/activities have been most beneficial to seniors' health, well-being and independence? Which have been least beneficial?

19. Would the health, well-being and independence of Canada's seniors have been affected if there had been no Division of Aging and Seniors/Seniors Strategy? If yes, how? If no, why not?

    ☐ Would your activities have taken place without the Division of Aging and Seniors/Seniors Strategy?

    ☐ Thinking of the future, would the health, well-being and independence of Canada's seniors be affected if there were no Division of Aging and Seniors/Seniors Strategy and, more generally, no Health Canada programming for seniors? Please explain.

III. Alternatives

20. Given the involvement of other federal government departments, provincial/territorial governments and non-government organizations, do you feel Health Canada should continue to maintain all of its activities under the Division of Aging and Seniors/Seniors Strategy?

    ☐ Could the responsibilities for some of these programs and activities be handed over to other federal departments, provincial/territorial governments, local governments or NGOs? Which ones and how?

    ☐ Do you have any ideas for new mechanisms or structures:

    - To meet seniors' needs in general?
    - To improve the health, well-being and independence of seniors?

    ☐ Which activities and expertise in seniors/aging issues currently supported by the Division of Aging and Seniors/Seniors Strategy should Health Canada definitely retain?

    - In what order of priority would you place these activities?

    ☐ Which types of programs/activities currently supported by the Division of Aging and Seniors/Seniors Strategy do you feel have been the most cost-effective? Explain.

    ☐ Which types of programs/activities have been less cost-effective? Explain.

IV. Further Questions (Only if Time Allows)

21. In your opinion, what groups can be considered as "at-risk" seniors? On what do you base your opinion?

- ☐ Does the Division of Aging and Seniors/Seniors Strategy have a role to play in addressing their needs? In what way?

22. Do you feel the Division of Aging and Seniors/Seniors Strategy reaches all major segments/types of seniors "at risk"? If yes, how? If no, why not? Which types of "at risk" seniors are not being reached?

23. To what extent is the Division of Aging and Seniors/Seniors Strategy meeting the most important needs of seniors, including seniors "at risk"? On what do you base your opinion?

24. Do you have any other comments?

THANK YOU FOR YOUR PARTICIPATION

INTERVIEW GUIDE

Stakeholders

Ekos Research Associates Inc. has been commissioned by Health Canada to conduct an evaluation of the success and continued relevance of the Division of Aging and Seniors/Seniors Strategy (DAS/S) as well as to identify possible alternatives to the strategy[1]. The Division of Aging and Seniors/Seniors Strategy is comprised of four program elements: 1) Seniors Community Programs Funding (i.e., New Horizons: Partners in Aging, and the former Seniors Independence Program, Ventures in Independence and New Horizons programs); 2) Seniors Independence Research Program; 3) Policy Coordination and Support to the Minister; and 4) National Advisory Council on Aging (NACA). Former and present Health Canada organizational units covered by the strategy include: the Seniors Secretariat; NACA Secretariat; Seniors Community Programs; Aging-Related Diseases Division; Health Policy; the National Health Research and Development Program (Seniors Independence Research Program component); Seniors Directorate; and Regional Offices.

The purpose of this interview is to obtain views on the impacts and overall relevance of the Division of Aging and Seniors/Seniors Strategy. The respondent should feel free to tell the interviewer if he/she does not feel confident enough to answer specific questions.

I. Background Information

1. What are the objectives and/or primary focus of your organization?

2. Are you/is your organization working with or receiving funds from programs or activities funded by the Division of Aging and Seniors/Seniors Strategy? Have you ever been involved with DAS/S?

   ☐ With what Division of Aging and Seniors/Seniors Strategy program or activity are you involved? What is the nature of your involvement?

   ☐ Do you/does your organization currently receive funds from the Division of Aging and Seniors/Seniors Strategy?

   - Have you ever received funding? Have you ever applied for funding?

II. Program Relevance

3. In your opinion, what are the most important needs of today's seniors? On what do you base your opinion?

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- ☐ Is there a relevant role for the federal government to take in addressing these needs? Is there a role for Health Canada? Please explain.

- ☐ Does the Division of Aging and Seniors/Seniors Strategy have a role to play in addressing these needs? In what way?

4. Is there a continuing role for the Division of Aging and Seniors/Seniors Strategy to play in:

   - ☐ improving and preserving the *health and well-being* of Canadian seniors? What should be this role? On what do you base your opinion?

   - ☐ improving and preserving the *independence* (living arrangements, transportation, social support networks) of Canadian seniors? What should be this role? On what do you base your opinion?

   - ☐ increasing society's *understanding and acceptance of seniors*? What should be this role? On what do you base your opinion?

   - ☐ *eliminating barriers to the involvement and participation of seniors in society*? What should be this role? On what do you base your opinion?

5. Do the activities under the Division of Aging and Seniors/Seniors Strategy *supplement or complement* the activities of other federal or provincial/territorial departments or NGOs, or do they *overlap*? If they overlap, in what way?

III. Program Accomplishments

6. Has the Division of Aging and Seniors/Seniors Strategy *increased and consolidated knowledge on aging and seniors*? If yes, how? If no, why not?

   - ☐ To what extent is this knowledge being shared with, disseminated to you/your organization, other stakeholders and other federal and provincial/territorial departments? If yes, how? If no, why not?

   - ☐ Have the research and knowledge development activities supported and/or undertaken by the Division of Aging and Seniors/Seniors Strategy met seniors's needs? How?

7. Has the Division of Aging and Seniors/Seniors Strategy provided seniors with the *information they need and the opportunity to make informed choices* on issues that affect their health, well-being and independence? On what do you base your opinion?

8. To what extent has the Division of Aging and Seniors/Seniors Strategy *developed and promoted integrated policies and strategies* that address the needs of

seniors for government and non-government organizations? On what do you base your opinion?

9. To what extent has the Division of Aging and Seniors/Seniors Strategy *promoted a positive and realistic image of seniors*? On what do you base your opinion?

10. To what extent is the Division of Aging and Seniors/Seniors Strategy supporting innovative projects? In what way?

    ☐ In what way have you/has your organization changed what you do as a result of the Division of Aging and Seniors/Seniors Strategy?

11. Have partnerships been developed as a result of Health Canada's activities in the Division of Aging and Seniors/Seniors Strategy?

    ☐ Partnershps between Health Canada and other levels of government? The private sector? Non-government organizations?

    ☐ Have partnerships been developed among these groups?

12. Are there any *unintended* effects (positive or negative) of the Division of Aging and Seniors/Seniors Strategy? Specify.

13. What are the overall strengths and weaknesses of the Division of Aging and Seniors/Seniors Strategy?

    ☐ Which types of programs/activities have been most beneficial to seniors' health, well-being and independence? Which have been least beneficial?

IV. Alternatives

14. Given the involvement of other federal government departments, provincial/territorial governments and non-government organizations, do you feel Health Canada should continue to maintain all of its activities under the Division of Aging and Seniors/Seniors Strategy?

    ☐ Could the responsibilities for some of these programs and activities be handed over to other federal departments, provincial/territorial governments, local governments or NGOs? Which ones and how?

    ☐ Do you have any ideas for new mechanisms or structures:

    - To meet seniors' needs in general?
    - To improve the health, well-being and independence of seniors?

- ☐ Which activities and expertise in seniors/aging issues currently supported by the Division of Aging and Seniors/Seniors Strategy should Health Canada definitely retain?
  - In what order of priority would you place these activities?
- ☐ Which types of programs/activities currently supported by the Division of Aging and Seniors/Seniors Strategy do you feel have been the most cost-effective? Explain.
- ☐ Which types of programs/activities have been less cost-effective? Explain.

V. Further Questions (Only if Time Allows)

15. In your opinion, what groups can be considered as "at-risk" seniors? On what do you base your opinion?
    - ☐ Does the Division of Aging and Seniors/Seniors Strategy have a role to play in addressing their needs? In what way?
16. Do you feel the Division of Aging and Seniors/Seniors Strategy reaches all major segments/types of seniors "at risk"? If yes, how? If no, why not? Which types of "at risk" seniors are not being reached?
17. To what extent is the Division of Aging and Seniors/Seniors Strategy meeting the most important needs of seniors, including seniors "at risk"? On what do you base your opinion?
18. Have networks between seniors and other sectors of society been developed through the Division of Aging and Seniors/Seniors Strategy? Have networks of researchers been developed? On what do you base your opinion?
19. Would the health, well-being and independence of Canada's seniors have been affected if there had been no Division of Aging and Seniors/Seniors Strategy? If yes, how? If no, why not?
    - ☐ Thinking of the future, would the health, well-being and independence of Canada's seniors be affected if there were no Division of Aging and Seniors/Seniors Strategy and, more generally, no Health Canada programming for seniors? Please explain.
20. Do you have any other comments?

THANK YOU FOR YOUR PARTICIPATION

INTERVIEW GUIDE

NACA Members

Ekos Research Associates Inc. has been commissioned by Health Canada to conduct an evaluation of the success and continued relevance of the Division of Aging and Seniors/Seniors Strategy (DAS/S) as well as to identify possible alternatives to the strategy[1]. The Division of Aging and Seniors/Seniors Strategy is comprised of four program elements: 1) Seniors Community Programs Funding (i.e., New Horizons: Partners in Aging, and the former Seniors Independence Program, Ventures in Independence and New Horizons programs); 2) Seniors Independence Research Program; 3) Policy Coordination and Support to the Minister; and 4) National Advisory Council on Aging (NACA). Former and present Health Canada organizational units covered by the strategy include: the Seniors Secretariat; NACA Secretariat; Seniors Community Programs; Aging-Related Diseases Division; Health Policy; the National Health Research and Development Program (Seniors Independence Research Program component); Seniors Directorate; and Regional Offices.

The purpose of this interview is to obtain views on the impacts and overall relevance of the Division of Aging and Seniors/Seniors Strategy. The respondent should feel free to tell the interviewer if he/she does not feel confident enough to answer specific questions.

I. Program Relevance

1. In your opinion, what are the most important needs of today's seniors? On what do you base your opinion?

   ☐ Is there a relevant role for the federal government to take in addressing these needs? Is there a role for Health Canada? Please explain.

   ☐ Does the Division of Aging and Seniors/Seniors Strategy have a role to play in addressing these needs? In what way?

2. Is there a continuing role for the Division of Aging and Seniors/Seniors Strategy to play in:

   ☐ improving and preserving the *health and well-being* of Canadian seniors? What should be this role? On what do you base your opinion?

   ☐ improving and preserving the *independence* (living arrangements, transportation, social support networks) of Canadian seniors? What should be this role? On what do you base your opinion?

   ☐ increasing society's *understanding and acceptance of seniors*? What should be this role? On what do you base your opinion?

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- ☐ *eliminating barriers to the involvement and participation of seniors in society?* What should be this role? On what do you base your opinion?

3. Do the activities under the Division of Aging and Seniors/Seniors Strategy *supplement or complement* the activities of other federal or provincial/territorial departments or NGOs, or do they *overlap*? If they overlap, in what way?

II. Program Accomplishments

4. Has the Division of Aging and Seniors/Seniors Strategy *increased and consolidated knowledge on aging and seniors*? If yes, how? If no, why not?

   - ☐ To what extent is this knowledge being shared with, disseminated to other stakeholders and other federal and provincial/territorial departments? If yes, how? If no, why not?

   - ☐ Have the research and knowledge development activities supported and/or undertaken by the Division of Aging and Seniors/Seniors Strategy met seniors's needs? How?

5. Has the Division of Aging and Seniors/Seniors Strategy provided seniors with the *information they need and the opportunity to make informed choices* on issues that affect their health, well-being and independence? On what do you base your opinion?

6. To what extent has the Division of Aging and Seniors/Seniors Strategy *developed and promoted integrated policies and strategies* that address the needs of seniors for government and non-government organizations? On what do you base your opinion?

   - ☐ What expertise has been provided to deliberations on policy/program development from the Division of Aging and Seniors/Seniors Strategy? Has this been useful? If yes, how? If no, why not?

7. To what extent has the Division of Aging and Seniors/Seniors Strategy *promoted a positive and realistic image of seniors*? On what do you base your opinion?

8. To what extent has the Division of Aging and Seniors/Seniors Strategy provided the National Advisory Council on Aging with:

   - ☐ Research support
   - ☐ Policy support
   - ☐ Communications support
   - ☐ Administrative support

9. Do you feel NACA has contributed to achieving Strategy objectives? Examples?

10. What would have happened to NACA without the Division of Aging and Seniors/Seniors Strategy?

11. Are there any *unintended* effects (positive or negative) of the Division of Aging and Seniors/Seniors Strategy? Specify.

12. What are the overall strengths and weaknesses of the Division of Aging and Seniors/Seniors Strategy?

    ☐ Which types of programs/activities have been most beneficial to seniors' health, well-being and independence? Which have been least beneficial?

III. Alternatives

13. Given the involvement of other federal government departments, provincial/territorial governments and non-government organizations, do you feel Health Canada should continue to maintain all of its activities under the Division of Aging and Seniors/Seniors Strategy?

    ☐ Could the responsibilities for some of these programs and activities be handed over to other federal departments, provincial/territorial governments, local governments or NGOs? Which ones and how?

    ☐ Do you have any ideas for new mechanisms or structures:

    - To meet seniors' needs in general?
    - To improve the health, well-being and independence of seniors?

    ☐ Which activities and expertise in seniors/aging issues currently supported by the Division of Aging and Seniors/Seniors Strategy should Health Canada definitely retain?

    - In what order of priority would you place these activities?

    ☐ Which types of programs/activities currently supported by the Division of Aging and Seniors/Seniors Strategy do you feel have been the most cost-effective? Explain.

    ☐ Which types of programs/activities have been less cost-effective? Explain.

IV. Further Questions (Only if Time Allows)

14. In your opinion, what groups can be considered as "at-risk" seniors? On what do you base your opinion?

    ☐ Does the Division of Aging and Seniors/Seniors Strategy have a role to play in addressing their needs? In what way?

15. Do you feel the Division of Aging and Seniors/Seniors Strategy reaches all major segments/types of seniors "at risk"? If yes, how? If no, why not? Which types of "at risk" seniors are not being reached?

16. To what extent is the Division of Aging and Seniors/Seniors Strategy meeting the most important needs of seniors, including seniors "at risk"? On what do you base your opinion?

17. Have networks between seniors and other sectors of society been developed through the Division of Aging and Seniors/Seniors Strategy? Have networks of researchers been developed? On what do you base your opinion?

18. Do you have any other comments?

THANK YOU FOR YOUR PARTICIPATION

INTERVIEW GUIDE

Groups/Organizations Turned Down for Funding

Ekos Research Associates Inc. has been commissioned by Health Canada to conduct an evaluation of the success and continued relevance of the Department's programs for seniors as well as to identify possible alternative approaches[1]. The programs for seniors include: 1) Seniors Community Programs Funding (i.e., New Horizons: Partners in Aging, and the former Seniors Independence Program, Ventures in Independence and New Horizons programs); 2) Seniors Independence Research Program; 3) Policy Coordination and Support to the Minister; and 4) National Advisory Council on Aging (NACA). Collectively, these programs are formally called the Division of Aging and Seniors/Seniors Strategy. Former and present Health Canada organizational units involved in these programs include: the Seniors Secretariat; NACA Secretariat; Seniors Community Programs; Aging-Related Diseases Division; Health Policy; the National Health Research and Development Program (Seniors Independence Research Program component); Seniors Directorate; and Regional Offices.

The purpose of this interview is to obtain views on the impacts and overall relevance of Health Canada's programs for seniors. The respondent should feel free to tell the interviewer if he/she does not feel confident enough to answer specific questions. Answers to the interview questions will not influence in any way current or future funding from Health Canada.

I. Background Information

1. Our files indicate that you applied to the [PROGRAM NAME] in [YEAR] for funding for [PROJECT NAME]. Is that correct?

   ☐ What were the objectives of your project?

   ☐ Did you receive funding from the [PROGRAM NAME]?

   - If yes, end interview.
   - If no, have the reasons you were turned down for funding ever been explained to you? If yes, did the explanation make sense to you?

   ☐ Did your project ever take place? If yes, what were your sources of funding?

2. Do you intend to apply for funding to the [PROGRAM NAME] or to other Health Canada programs for seniors in the future?

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II. Program Relevance

3. Are you familiar with the objectives of Health Canada's programs for seniors?

   ☐ New Horizons: Partners in Aging
   ☐ Seniors Independence Program
   ☐ Ventures in Independence
   ☐ New Horizons programs
   ☐ Seniors Independence Research Program

4. Do the Health Canada programs *supplement or complement* the activities of other federal or provincial/territorial departments or non-government organizations, or do they *overlap*? If they overlap, in what way?

III. Program Accomplishments

5. What have been the impacts and effects of Health Canada's programs for seniors on: *(Please respond only if you feel confident enough to answer.)*

   ☐ Individual Canadian seniors?
   ☐ Health and other professionals working with seniors?
   ☐ Government policies and programs?
   ☐ The work of other organizations?
   ☐ At the national, provincial and/or local level?

6. Have partnerships been developed as a result of Health Canada's program funding? *(Please respond only if you feel confident enough to answer.)*

   ☐ Partnerships between Health Canada and other levels of government? The private sector? Non-government organizations?

   ☐ Have partnerships been developed among these groups?

   ☐ What types of partnerships:

   - financial partnerships?
   - ongoing working relationships?
   - shared policy reviews?
   - other?

7. Are there any *unintended* effects (positive or negative) of Health Canada's programs? Specify.

8. In your opinion, what are the overall strengths and weaknesses of Health Canada's programs for seniors?

IV. Alternatives

9. Given the involvement of other federal government departments, provincial/territorial governments and non-government organizations, do you feel Health Canada should continue to maintain all of the activities/programs funded under its programs for seniors?

- ☐ Could the responsibilities for some of these programs and activities be handed over to other federal departments, provincial/territorial governments, local governments or NGOs? Which ones and how?
- ☐ Could some activities/programs be eliminated entirely? Which ones?
- ☐ Do you have any ideas for new mechanisms or structures:
  - To meet seniors' needs in general?
  - To improve the health, well-being and independence of seniors?
- ☐ Which activities and expertise in seniors/aging issues should the federal government definitely retain?
  - Is Health Canada the most appropriate department to deliver these programs/activities?
  - Which activities should Health Canada definitely retain?
  - In what order of priority would you place these activities?
- ☐ Which types of programs/activities currently supported by Health Canada do you feel have been the most cost-effective? Explain.
- ☐ Which types of programs/activities have been less cost-effective? Explain.

IV. Further Questions (Only if Time Allows)

10. In your opinion, what groups can be considered as "at-risk" seniors? On what do you base your opinion?

- ☐ What are their most important needs?
- ☐ Does Health Canada have a role to play in addressing their needs? In what way?

11. Do you feel the Health Canada programs reach some major segments/types of seniors "at risk"? If yes, how? If no, why not?

12. To what extent are Health Canada's programs meeting some of the important needs of seniors, including seniors "at risk"? On what do you base your opinion?

13. Do you have any other comments?

THANK YOU FOR YOUR PARTICIPATION

APPENDIX E
Distribution of Interviews

Distribution of Key Informant Interviews

EXHIBIT E.1
Completed Central Agency Key Informant Interviews

Type of Interviewee	Interviewee Sub-Group	Number of Interviews
Central Agencies	Treasury Board	1
	Privy Council Office	1
TOTAL		2

EXHIBIT E.2
Completed Health Canada Senior Managers and Staff Key Informant Interviews

Type of Interviewee	Interviewee Sub-Group	Number of Interviews
Health Canada Senior Managers and Staff	Headquarters	16
	Regional offices	12
TOTAL		28

EXHIBIT E.3
Completed Provincial/Territorial Key Informant Interviews

Type of Interviewee	Interviewee Sub-Group	Number of Interviews
Provincial/Territorial	British Columbia	2
	Yukon	1
	Alberta	2
	Northwest Territories	1
	Saskatchewan	2
	Manitoba	2
	Ontario	2
	Quebec[1]	0
	New Brunswick	1
	Nova Scotia	1
	Newfoundland and Labrador	1
	Prince Edward Island	1
TOTAL		16

EXHIBIT E.4
Completed Successful Funding Applicants Key Informant Interviews

Type of Interviewee	Interviewee Sub-Group	Number of Interviews
Successful Funding Applicants	SIRP	4
	Ventures	2
	NH	4
	NH:PA	4
	SIP	3
TOTAL		17

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[1] Two interviews were intended to be held with representatives from Quebec. The Government of Quebec, however, declined to participate in the study.

EXHIBIT E.5
Completed Unsuccessful Funding Applicants Key Informant Interviews

Type of Interviewee	Interviewee Sub-Group	Number of Interviews
Unsuccessful Funding Applicants	SIRP	2
	Ventures	1
	NH	3
	NH:PA	3
	SIP	1
TOTAL		10

APPENDIX F
Survey Instruments

Survey of Intended Beneficiaries

INTRODUCTION, NOTE TO INTERVIEWERS: Address respondent as Mr. or Mrs.

Hello, may name is ___ and I work for Ekos Research Associates. We have been hired by Health Canada to conduct an evaluation of the department's aging and seniors programs. . This study will gather opinions about the different programs offered by the government to assist seniors and about the priorities for the federal government in the future. We would like to ask you a few questions about the <proj
Your participation in this survey is completely voluntary and refusal to participate will not affect any services which you may receive from the government now or in the future. All the information you provide will be protected under the Privacy Act and you can request the report under the Access to Information Act. You may also decline to answer any questions you do not feel comfortable with. The interview will take about 20 minutes of your time. Is this a convenient time?
@invit (1=yes, 2=no)

1: **INVIT**
Introduction.
01 Yes 1
02 No . . . . 2 => INT

2: **SENIO**
In what year were you born? IF INDIVIDUAL IS LESS THAN 65 (I.E., BORN AFTER 1931 (E.G., 1932)) THANK AND EXIT INTERVIEW
01 Less than 65 . . . . 01 => INT
02 DK/NR 99

3: **INTR3**
First, I'd like to confirm our information. According to our records, in the past five years, you participated in a federally funded project or received a service called <proj > through the <spon >. Is that correct?
01 Yes . . . . 1 => +2
02 No 2

4: **OFFER**
Your name was provided to us by <head > from the <spon >. Do you remember participating in this activity or receiving this service?
01 Yes 1
02 No . . . . 2 => INT
03 DK/NR 9

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5: **DESCP**

What was the main activity or service you received?

01	Physical activity, sport, fitness	01	
02	Heath-related services such as foot care	02	
03	Social activities	03	
04	Meals/meal preparation	04	
05	Educational services, information sessions	05	
06	Received booklet or publication	06	
07	Other	07	
08	DK/NR	99	

6: **HEATH**

Did the services/activities help you maintain or improve your health, well-being and/or independence in any way?

01	Yes	1	
02	No	2	=> +2
03	DK/NR	9	=> +2

7: **TYPE**

In what way?

01	Response	01	
02	DK/NR	99	

8: **ALTEN**

Do you know of any programs or projects in the community that offered similar activities/services as those under the <proj >?

01	Yes	1	
02	No	2	=> +2
03	DK/NR	9	

9: **NEW**

Do you now participate in these programs or projects with similar activities/services?

01	Yes	1	
02	No	2	
03	DK/NR	9	

10: **OTHER**

Do you now participate in any other programs or receive any other services specifically for seniors?

01	Yes	1	
02	No	2	=> +2
03	DK/NR	9	

11: KINDS

MESSAGE: PROMPT IF NECESSARY, CHOOSE ALL THAT APPLY

What kinds of seniors services or programs?

01	Assistance with housework	01
02	Help with meals	02
03	Transportation	03
04	Social activities/club/drop-in centre	04
05	Fitness/sport	05
06	Health services	06
07	Special skills services	07
08	Social services	08
09	Education/ information services/programs	09
10	Respite care/assistance to caregivers	10
11	Home care	11
12	Other (specify)	12
13	DK/NR	99

12: FAMIL

Do you receive any assistance (e.g., around the house, in getting around) from your family and friends? IF YES - Probe for "a lot" of assistance or "some" assistance

01	Yes, lots	1
02	Yes, some	2
03	No	3
04	DK/NR	9

13: AFSUP

MESSAGE: READ LIST

How would you rate the availability of support that could be provided by your family, friends and/or neighbours if you needed it? Would you say....

01	More than I do or would need	1
02	As much as I need	2
03	Less than I do or would need	3
04	DK/NR	9

14: DOTHI

Would you agree, disagree or neither agree nor disagree with the following statement: "I have someone in my life whom I do things with and can confide in".

01	Agree	1
02	Neither agree nor disagree	2
03	Disagree	3
04	DK/NR	9

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15: ISSUP

MESSAGE: PLEASE NUMBER EACH RESPONSE 1,2

What are the two biggest issues currently threatening the health, well being and independence of Canadian seniors today? Please start by giving me the one you consider most important.

01	Response	01
02	DK/NR	99

16: RESP

MESSAGE: ONE ONLY

In the area of aging and seniors issues overall, who do you think should have PRIMARY responsibility. Should it be...

01	Government	01
02	Non-profit or voluntary organizations	02
03	Individuals in general	03
04	Seniors	04
05	Other	05
06	DK/NR	99

17: LEVEL

=> +1 if NOT(RESP=#1)

What level of government should have primary responsibility for aging and seniors issues?

01	Federal	1
02	Provincial	2
03	Local/municipal	3
04	DK/NR	9

18: INVOL

MESSAGE: READ LIST

Overall, in the area of aging and seniors issues, what would you like to see the federal government do in the future for ALL Canadian seniors. Would you say....

01	Increase its level of support	1
02	Maintain its current level of support	2
03	Reduce its level of support	3
04	Eliminate support4	4
05DK/NR		9

19: INVO2

MESSAGE: READ LIST

Overall, in the area of aging and seniors issues, what would you like to see the federal government do in the future for LOW INCOME Canadian seniors. Would you say....

01	Increase its level of support	1
02	Maintain its current level of support	2
03	Reduce its level of support	3
04	Eliminate support4	4
05DK/NR		9

20: LOWIN

Some people argue that those who can pay, should, and only low income seniors should receive government-supported services. Do you agree with this statement, disagree or neither agree nor disagree?

01	Agree	1
02	Neither agree nor disagree	2
03	Disagree	3
04	DK/NR	9

21: PRIOR

The government will face a number of challenges as Canadians age. For each of the following areas, I'd like you to tell me whether you think the government should, for all Canadian seniors, increase its support, maintain support at the same level it is now or reduce its support.

22: PENS

MESSAGE: ...what the government should do

....income security such as pensions and income tax credits NOTE: IF respondent says increase or reduce, probe from "alot" or "a little"

01	Increase support alot	1
02	Increase support a little	2
03	Maintain support at the same level as now	3
04	Reduce support a little	4
05	Reduce support a lot	5
06	DK/NR	9

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23: PBLH
MESSAGE: ...what the government should do
....basic health care coverage NOTE: IF respondent says increase or reduce, probe for "a lot" or "a little"

01	Increase support alot	1
02	Increase support a little	2
03	Maintain support at the same level as now	3
04	Reduce support a little	4
05	Reduce support a lot	5
06	DK/NR	9

24: EBENE
MESSAGE: ...what the government should do
....extended health care benefits for prescription drugs NOTE: IF respondent says increase or reduce, probe for "alot" or "a little"

01	Increase support alot	1
02	Increase support a little	2
03	Maintain support at the same level as now	3
04	Reduce support a little	4
05	Reduce support a lot	5
06	DK/NR	9

25: INTER
MESSAGE: ...what the government should do
....health care benefits for out-of-country care NOTE: IF respondent says increase or reduce, probe for "a lot" or "a little"

01	Increase support alot	1
02	Increase support a little	2
03	Maintain support at the same level as now	3
04	Reduce support a little	4
05	Reduce support a lot	5
06	DK/NR	9

26: AFFOR
MESSAGE: ...what the government should do
....specialized housing (e.g., retirement building with on-site support, adapted housing for seniors, etc.) NOTE: IF respondent says increase or reduce, probe for "alot" or "a little"

01	Increase support alot	1
02	Increase support a little	2
03	Maintain support at the same level as now	3
04	Reduce support a little	4
05	Reduce support a lot	5
06	DK/NR	9

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27: ACCES

MESSAGE: ...what the government should do

....accessible transportation NOTE: IF respondents says increase or reduce, probe for "a lot" or "a little"

01	Increase support alot	1
02	Increase support a little	2
03	Maintain support at the same level as now	3
04	Reduce support a little	4
05	Reduce support a lot	5
06	DK/NR	9

28: HOME

MESSAGE: ...what the government should do

...home care or home support services (e.g., homemaker services, assistance with bathing, meal preparation, nursing, etc.) NOTE: IF respondent says increase or reduce, probe for "a lot" or "a little"

01	Increase support alot	1
02	Increase support a little	2
03	Maintain support at the same level as now	3
04	Reduce support a little	4
05	Reduce support a lot	5
06	DK/NR	9

29: RESPT

MESSAGE: ...what the government should do

....services to help those who are caring for an elderly relative or friend NOTE: IF respondent says increase or reduce, probe for "a lot" or "a little"

01	Increase support alot	1
02	Increase support a little	2
03	Maintain support at the same level as now	3
04	Reduce support a little	4
05	Reduce support a lot	5
06	DK/NR	9

30: PALL

MESSAGE: ...what the government should do

...specialized care services for dying patients NOTE: If respondent says increase or reduce, probe for "a lot" or "a little"

01	Increase support alot	1
02	Increase support a little	2
03	Maintain support at the same level as now	3
04	Reduce support a little	4
05	Reduce support a lot	5
06	DK/NR	9

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31: PWELL

MESSAGE: ...what the government should do

....programs and information for seniors on topics like exercise, nutrition, accident-prevention, medication use, etc NOTE: IF respondent says increase or reduce, probe for "a lot" or "a little"

01	Increase support alot	1
02	Increase support a little	2
03	Maintain support at the same level as now	3
04	Reduce support a little	4
05	Reduce support a lot	5
06	DK/NR	9

32: COMMC

MESSAGE: ...what the government should do

....organizations for seniors NOTE: IF respondents says increase or reduce, probe for "a lot" or "a little"

01	Increase support alot	1
02	Increase support a little	2
03	Maintain support at the same level as now	3
04	Reduce support a little	4
05	Reduce support a lot	5
06	DK/NR	9

33: KNOW

MESSAGE: ...what the government should do

...providing information to seniors about health, well-being and independence

01	Increase support alot	1
02	Increase support a little	2
03	Maintain support at the same level as now	3
04	Reduce support a little	4
05	Reduce support a lot	5
06	DK/NR	9

34: INFO

MESSAGE: ...what the government should do

....improving the public image of aging and seniors NOTE: IF respondent says increase or reduce, probe for "a lot" or "a little"

01	Increase support alot	1
02	Increase support a little	2
03	Maintain support at the same level as now	3
04	Reduce support a little	4
05	Reduce support a lot	5
06	DK/NR	9

35: **LEAD**

MESSAGE: ...what the government should do

....guiding and coordinating other organizations across the country regarding seniors issues

01	Increase support alot	1
02	Increase support a little	2
03	Maintain support at the same level as now	3
04	Reduce support a little	4
05	Reduce support a lot	5
06	DK/NR	9

36: **RESE**

MESSAGE: ...what the government should do

....research funding on the health concerns of seniors such as osteoporosis or Alzheimers disease NOTE: If respondent says increase or reduce, probe for "a lot" or "a little"

01	Increase support alot	1
02	Increase support a little	2
03	Maintain support at the same level as now	3
04	Reduce support a little	4
05	Reduce support a lot	5
06	DK/NR	9

37: **RISK**

MESSAGE: ...what the government should do

....benefits for medical devices and aids such as hearing aids and walkers NOTE: IF respondent says increase or reduce, probe for "alot" or "a little"

01	Increase support alot	1
02	Increase support a little	2
03	Maintain support at the same level as now	3
04	Reduce support a little	4
05	Reduce support a lot	5
06	DK/NR	9

38: **NONSE**

Overall, how would you say non-seniors perceive seniors and aging in Canada today? Would you say people generally have a....

01	positive view	1
02	mixed view	2
03	negative view	3
04	DK/NR	9

39: **PRE57**

Finally, I would like to ask you a few questions for statistical purposes. I remind you that all of your responses will be protected and no answers will be reported individually.

40: **RETIR**

Are you currently retired, semi-retired, a homemaker, employed outside the home or self-employed? (RETIRED MEANS THEY WERE IN THE WORKFORCE AT SOMETIME, HOMEMAKER MEANS THEY NEVER WORKED OUTSIDE OF THE HOME)

01	Retired	1
02	Homemaker	2
03	Employed outside the home	3
04	Self-employed	4
05	Other (specify)	5
06	Semi-retired	6
07	DK/NR	9

[illegible]

41: **I2**

=> +1 if NOT(RETIR=#3-#4)

MESSAGE: SELECT ALL THAT APPLY - DO NOT READ CATEGORIES

Are you working part-time or full-time?

01	Part-time	1
02	Full-time	2
03	DK/NR	9

42: **VOL**

Do you do any volunteer work for groups or organizations? IF YES: Probe for "lots" or "some"

01	Yes, lots	1
02	Yes, some	2
03	No	3
04	DK/NR	9

43: **VOLLF**

Do you spend time helping out family, friends or neighbours? IF YES: Probe for "lots" or "some"

01	Yes, lots	1
02	Yes, some	2
03	No	3
04	DK/NR	9

44: **Q59**

What is your current marital status?

01	Now married/common law	1
02	Widowed	2
03	Single (i.e., never married)	3
04	Separated or divorced	4
05	DK/NR	9

45: HEALT

In general, compared to other people your age, would you say your health and well-being is very good, average, or poor.

01	Very good	1
02	Average	2
03	Poor	3
04	DK/NR	9

46: DIS

Do you have a chronic or long-term illness, injury or disability that limits your physical independence?

01	Yes	1	
02	No	2	=> +1
03	DK/NR	9	

47: SPECI

MESSAGE: READ CATEGORIES

To what extent would you say your physical independence is limited by an illness, injury or disability? Would you say...

01	A great deal	1
02	Somewhat	2
03	A little	3
04	DK/NR	9

48: IMPRO

Did you do something to improve your health in the past 12 months?

01	Yes	1	
02	No	2	=> +3
03	DK/NR	9	

49: SINGL

What is the single most important change you have made in the past 12 months to improve your health?

01	Increased physical activity	01
02	Lost weight	02
03	Changed eating habits	03
04	Managed blood pressure	04
05	Change physical environment	05
06	Acquired an assistance device or medical aid	06
07	Received better care services	07
08	Changed medication	08
09	Other (specify)	09
10	DK/NR	99

50: HELP

MESSAGE: READ CATEGORIES, CHOOSE ALL THAT APPLY

Did any of the following help you to make this change? PROBE: Any other factors which helped you make this change?

01	Support from family or friends	01
02	Increased knowledge of health risks	02
03	Changes in legislation or policies	03
04	Change in life situation	04
05	Advice from health professional	05
06	None of the above	09
07	Other	07
08	DK/NR	99

51: EDUC

What is the highest level of formal education that you have completed?

01	No schooling	01
02	Primary school	02
03	Some high school	03
04	High school graduate	04
05	Some community college/CEGEP	05
06	Community college/CEGEP graduate	06
07	Some university	07
08	Undergraduate degree (e.g., B.A., B.Sc.)	08
09	Graduate or post graduate degree (e.g., M.A., M.Sc., Ph.D.)	09
10	Other (specify)	10
11	DK/NR	99

52: WHERE

MESSAGE: PROMPT WITH CATEGORIES

What kind of place do you live in?

01	Private residence	01	
02	Retirement home	02	=> SIZE
03	Institutional facility	03	=> SIZE
04	Other (specify)	04	=> SIZE
05	DK/NR	99	=> SIZE

53: NUMB

How many people, including yourself, live in your residence?

01	DK/NR	99

54: SIZE

What is the approximate size of the community in which you live?

01	Less than 10,000	1
02	10,000 to 99,999	2
03	100,000 to 1 million	3
04	1 million plus	4
05	DK/NR	9

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55: CULT

What is the language you first learned in childhood and still understand?

01	English	01
02	French	02
03	Other	03

Which of the following three statements best describes your current financial situation.

I can meet my needs and still have enough money left over to do the things I want.

I have enough money to meet my needs but have little left over for extras.

I can barely meet my needs and have nothing left over for extras.

@meet
1 - Can meet needs and have money left over
2 - Enough to meet needs but little left over
3 - Barely meet needs
9 - DK/NR

56: MEET

01	Extras	1
02	Little for extras	2
03	Barely meet needs	3
04	DK/NR	9

57: HOU

MESSAGE: ALLOW RESPONDENTS CHOICE OF DECLINING TO RESPOND IF NOT COMFORTABLE

Approximately what was your total annual household income before deductions in the year ending December 31, 1995? Would it be.....

01	Less than $10,000	1
02	$10,000 to $14,999	2
03	$15,000 to $19,999	3
04	$20,000 to $29,999	4
05	$30,000 or over	5
06	DK/NR	9

58: SEX

MESSAGE: DO NOT READ

SEX

01	Male	1
02	Female	2

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59: THNK

MESSAGE: End of Interview

Thank you for your cooperation and time!

01	Completion	1

60: INT

MESSAGE: END OF INTERVIEW elapsed:$T $D $H

ENTER COMPLETION CODE

Elimination => 1 (NOT THNK)

01	Completed interview	CO	=> END
02	A business	BU	=> END
03	Number Not in Service	NF	=> END
04	Incomplete interview-->call back	IC	=> CB
05	No answer/Busy/Eligible Respondent not in-> call back .	NA	=> CB
06	Appointment for later time	AP	=> CB
07	Refusal	RF	=> END
08	Language Difficulty with Respondent/Hearing impairment .	LN	=> END
09	Ineligible to Participate/Screened Out	IN	=> END
10	Unavailable for the Survey Duration	UN	=> END
11	Called TEN times without success	RE	=> END
12	Deceased/TOO ILL TO PARTICIPATE	DE	=> END
13	To be called back by a francophone interviewer.	FR	=> CB
14	Incomplete refusal	IR	=> END

61: CB

MESSAGE: It is now $h Il est maintenant $H

ENTER A DATE AND TIME TO CALL THIS NUMBER BACK

62: DUM_1

=> END if 0==0

63: DUM_2

64: DUM_3

65: DUM_4

66: DUM_5

67: DUM_6

68: F6
Note fields for interviewers

```
@f6
Name of respondent:   <conta
Telephone number:     <tele        >

@not1
@not2
@not3
@not4
@not5
@not6
@not7
@not8
@not9
@not10
```

69: NOT1

70: NOT2

71: NOT3

72: NOT4

73: NOT5

74: NOT6

75: NOT7

76: NOT8

77: NOT9

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78: NOT10

```
@F7
NAME OF RESPONDENT:  @CONTA
ADDRESS:             @STREE
                     @CITY
                     @PROV
                     @POST
TELEPHONE NUMBER:    @TELE

TITLE OF PROJECT:    @PROJ
NUMBER OF PROJECT:   @CODE
TYPE OF PROGRAM:     @PROG
 New Horizons Parterns in Aging-1, New Horizons-2, SIP-3, Ventures-4, Other-5
START DATE:          @START
END DATE:            @LAST
SPONSOR:             @SPON
HEAD OF ORG.:        @HEAD
RANDOM:              @RAND
```

79: F7
=> +1 if 0==0

80: CONTA
Contact name of respondent

81: STREE
STREET ADDRESS

82: CITY
CITY

83: PROV
PROVINCE

```
01  NF . . . . . . . . . . . . . . . . . . . . . . . . . . .   NF
02  NOVA SCOTIA . . . . . . . . . . . . . . . . . . . . . . .   NS
03  NEW BRUNSWICK . . . . . . . . . . . . . . . . . . . . . .   NB
04  PRINCE EDWARD ISLAND . . . . . . . . . . . . . . . . . .   PE
05  quebec . . . . . . . . . . . . . . . . . . . . . . . . .   PQ
06  ontario . . . . . . . . . . . . . . . . . . . . . . . .   ON
07  manitoba . . . . . . . . . . . . . . . . . . . . . . . .   MB
08  saskatchewan . . . . . . . . . . . . . . . . . . . . . .   SK
09  ALBERTA . . . . . . . . . . . . . . . . . . . . . . . .   AB
10  BC . . . . . . . . . . . . . . . . . . . . . . . . . . .   BC
11  Northwest Territories . . . . . . . . . . . . . . . . .   NW
12  Yukon . . . . . . . . . . . . . . . . . . . . . . . . .   YK
```

84: POST
POSTAL CODE

85: TELE
TELEPHONE NUMBER

86: PROJ
Title of project

87: CODE
Number of project

88: PROG
Program type
01 New Horizons: Partners in Aging 1
02 New Horizons 2
03 SIP 3
04 Ventures 4
05 Other 5

89: START
Start year of project

90: LAST
End year of project

91: SPON
Name of project sponsor

92: HEAD
Head of project

93: RAND
From random or non-random pile
01 Random 1
02 Non-random 2

94: F10

Choose among the following themes:

01	Client F10_1	1	=>
02	Confidentiality F10_2	2	=>
03	How did you get my name F10_3	3	=>
04	Study topic F10_4	4	=>
05	Prompt on why personal information asked in survey. F10_5	5	=>
06	Who to call for more information F10_6	6	=>
07	How to access info under Privacy Act F10_7	7	=>
08	What is the Division of Aging and Seniors F10_8	8	=>
09	Return to the interview F10_9	9	=>

95: F10_1

This evaluation study is being conducted by Ekos on behalf of the federal department, Health Canada.

01	OK, return to the help menu	1	=> F10

96: F10_2

All information you give will be protected under the provisions of the Privacy Act. The information collected will be used for research purposes only. The report that will be written will give aggregate totals only, and no comments will be attributed to any individual. If you wish to discuss this survey you may talk to my supervisor, or to the survey coordinator at Ekos, Janice Remai collect at (613) 235-7225.

01	OK, return to the help menu	1	=> F10

97: F10_3

Your name was obtained from the manager of the program/project which was selected at random for this study and this information was used to contact you. This information was released for research purposes only.

01	OK, return to the help menu	1	=> F10

98: F10_4

This survey is part of research conducted by Health Canada. Interviews are being conducted with @ 500 seniors who have participated in projects funded by the Division of Aging & Seniors through New Horizons:Partners in Aging, New Horizons, Venture in Independence & Seniors Independence Program. The results of the study will be used by the department to help evaluate the effectiveness of the government's programs for seniors & to improve the programs in the future.

01 OK, return to the help menu . . . . 1 => F10

99: F10_5

Some of the questions in this survey involve personal questions about you. The purpose of these questions is to fully understand how Canadians are affected by aging in all areas of their life. This information is protected by the Privacy Act and information reported will be given in aggregate totals only, no comments will be attributed to one individual.

INDIVIDUAL.

01 OK, return to help menu . . . . 1 => F10

100: F10_6

If you need more information, you may call the survey manager at Ekos, Janice Remai collect at (613) 235-7225. If you want more information about the federal government's seniors program, you may contact the Division of Aging and Seniors at Health Canada at (613) 952-7606. If you would like more information about this evaluation study you may contact Linda Ladouceur collect at (613) 957-3897.

01 OK, return to help menu . . . . 1 => F10

101: F10_7

The information you provide will be stored in Personal Information Bank no. HC-002-085-9619 should you wish to obtain information pertaining to this survey, you may submit a request under the Privacy Act or the Access to Information Act, to Health Canada, stating the specific information you would like, and the personal information bank in which it is stored. Instructions for obtaining this information are provided in the publication "Info Source".

01 OK, return to help menu . . . . 1 => F10

102: F10_8

The Division of Aging and Seniors provides funding for programs and research to address issues around aging and seniors. There were three funding programs until 1995: New Horizons, Ventures in Independence, and Seniors Independence Program. These programs were combined in 1995 to form New Horizons:Partners in Aging. The objective of the Division is the improve the health, independence and well-being of seniors in Canada.

01 OK, return to help menu . . . . 1 => F10

103: F10_9

TYPE "ENTER" TO CONTINUE THE INTERVIEW

Survey of General Public Clients

INTRODUCTION

Hello, may name is ___ and I work for Ekos Research Associates. We have been hired by Health Canada to conduct an evaluation of the department's aging and seniors programs. This study will gather opinions about the different programs offered by the government to assist seniors and about the priorities for the government in the future. We are interviewing people who have contacted the department for information, advice or referral in the past two years. Your participation in this survey is completely voluntary and refusal to participate will not affect any services which you may receive from the government now or in the future. All the information you provide will be protected under the Privacy Act and you can request the report under the Access to Information Act. The interview will take about 20 minutes of your time. You may also decline to answer any question you do not feel comfortable with. Is this a convenient time?

@invit (1=yes, 2=no)

1: **INVIT**

Introduction.

01 Yes 1
02 No . . . . 2 => INT

2: **INTR3**

=> +2 if LIST=#2

First, I'd like to confirm our information. According to our records, you contacted the Division of Aging and Seniors, or the Seniors Directorate at Health Canada or the National Advisory Council on Aging in the past two years, for information, advice or a referral to another organization. This contact might have been made by telephone, fax, e-mail, or through a written request. Is that correct?

01 Yes . . . . 1 =>
SENIO . . . .
02 No 2

3: **PROME**

Are you sure? For example, you may have written a letter requesting a publication on seniors health issues, telephoned to get a referral to another department or organization, or the Division of aging and seniors may have sent your request to the appropriate department on your behalf.

01 Yes, I did make an enquiry 1
02 No . . . . 2 => INT

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4: **INTR4**

=> +2 if LIST=#1

First, I'd like to confirm our information. According to our records, you have been on the mailing list to receive various publications from either the Division of Aging and Seniors, the Seniors Directorate at Health Canada or the National Advisory Council on Aging. Is that correct?

01	Yes	1	=> +2
02	No	2	

5: **PROMM**

Are you sure? Examples of publications you may have received include the Seniors Info-Exchange, research reports or NACA publications (e.g., position papers, Writings in Gerontology, Forum collection papers, Vignette fact sheets).

01	Yes, I was on the mailing list	1	
02	No	2	=> INT

6: **SENIO**

First, to help us with the interview, in what year were you born?

01	DK/NR	99

7: **CALC**

=> * if 96-SENIO

Calculate age of respondent

8: **AWAR**

How did you first hear about Health Canada's programs for aging and seniors?

01	Word of mouth (family, friends)	01
02	From other health or social service professionals (e.g., nurse, social worker)	02
03	Through a seniors association or organization	03
04	Through a publication	04
05	Flyer or brochure	05
06	Through Health Canada booth	06
07	Through a presentation at a conference	07
08	Advertisement - radio, newspaper, television	08
09	Other	09
10	DK/NR	99

9: **SERV**

What was the main reason why you contacted Health Canada's aging and seniors programs?

01 INFORMATION about other government programs dealing with seniors (e.g., pensions, health services) 01
02 INFORMATION about a specific issue (e.g., osteoporosis, mobility aids) 02
03 INFORMATION about receiving/applying for funding under a particular program03
04 RESEARCH, publications on seniors issues 04
05 REFERRAL to another service or government program . . . 05
06 SPECIALIZED ADVICE on a specific issue 06
07 REFERRED BY another organization 07
08 To seek support or partnership for a project 08
09 Other 09
10 DK/NR 99

10: **TOPIC**

MESSAGE: CHOOSE ALL THAT APPLY

On what subject were you interested in obtaining information, advice or referral?

01 Medicare 01
02 Nursing homes/institutions 02
03 Benefits like prescription drugs 03
04 Assistive devices 04
05 Social support services (services for seniors, seniors' groups) 05
06 Household support services (e.g., services for yard work, household chores)06
07 Financial, economic issues (pension, old age security) . 07
08 Housing 08
09 Mobility, accessibility 09
10 Personal safety and security 10
11 Employment (e.g., mandatory retirement legislation, older worker issues) 11
12 Other 12
13 DK/NR 99

11: **ORG**

Did you contact Health Canada for yourself, on behalf of an organization or on behalf of another person?

01 For myself . . . . 1 => +3
02 On behalf of organization . . . . 2 => +3
03 On behalf of another person 3
04 DK/NR . . . . 9 => +3

12: **BEHAL**

=> +2 if NOT(ORG=#3)

On whose behalf did you contact Health Canada's seniors and aging programs?

01 Parent 1
02 Friend 2
03 Neighbour 3
04 Spouse 4
05 Other 5
06 DK/NR 9

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13: **CARE**
Do you have primary responsibility for the care of this person?

01	Yes	1
02	No	2
03	DK/NR	9

14: **RCON**
What was the result of your contact with Health Canada?

01	Referred to another organization	01
02	Received information/publication in the mail	02
03	Received information over the telephone	03
04	Other (specify)	04
05	DK/NR	99

15: **RESUL**
Did your contact with Health Canada's seniors and aging programs meet your expectations?

01	Yes	1
02	No	2
03	DK/NR	9

16: **SATIS**
How would you rate the information and service that you received from Health Canada's seniors and aging programs? For each of the following, would you say you are satisfied, neither satisfied nor dissatisfied, or dissatisfied.

17: **PROMP**
=> +1 if NOT(RCON=#2-#4) OR LIST=#2
MESSAGE: How would you rate your satisfaction in the area of....
PROMPTNESS IN RECEIVING THE INFORMATION/MATERIAL YOU REQUESTED

01	Satisfied	1
02	Neither satisfied nor dissatisfied	2
03	Dissatisfied	3
04	DK/NR	9

18: **UNDER**
=> +1 if LIST=#2
MESSAGE: How would you rate your satisfaction in the area of....
UNDERSTANDING OF YOUR REQUEST/PROBLEM

01	Satisfied	1
02	Neither satisfied nor dissatisfied	2
03	Dissatisfied	3
04	DK/NR	9

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19: SOUR

=> +1 if NOT(RCON=#1) OR LIST=#2

MESSAGE: How would you rate your satisfaction in the area of....

ABILITY TO REFER YOU TO THE APPROPRIATE SOURCE....

01	Satisfied	1
02	Neither satisfied nor dissatisfied	2
03	Dissatisfied	3
04	DK/NR	9

20: DELIV

=> +1 if NOT(RCON=#2-#4) OR LIST=#2

MESSAGE: How would you rate your satisfaction in the area of....

ABILITY TO ACTUALLY DELIVER ON YOUR REQUEST

01	Satisfied	1
02	Neither satisfied nor dissatisfied	2
03	Dissatisfied	3
04	DK/NR	9

21: RELE

=> +1 if NOT(RCON=#2-#4)

MESSAGE: How would you rate your satisfaction in the area of....

RELEVANCE OF THE INFORMATION, PUBLICATION OR ADVICE YOU RECEIVED

01	Satisfied	1
02	Neither satisfied nor dissatisfied	2
03	Dissatisfied	3
04	DK/NR	9

22: CLAR

=> +1 if NOT(RCON=#2-#4)

MESSAGE: How would you rate your satisfaction in the area of....

CLARITY OF THE INFORMATION,PUBLICATION,ADVICE (EASY TO UNDERSTAND)

01	Satisfied	1
02	Neither satisfied nor dissatisfied	2
03	Dissatisfied	3
04	DK/NR	9

23: USE

=> +1 if NOT(RCON=#2-#4)

MESSAGE: How would you rate your satisfaction in the area of....

USEFULNESS OF THE INFORMATION, PUBLICATION OR ADVICE YOU RECEIVED

01	Satisfied	1
02	Neither satisfied nor dissatisfied	2
03	Dissatisfied	3
04	DK/NR	9

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24: **EXTRA**
=> +1 if NOT(RCON=#2-#4)
MESSAGE: How would you rate your satisfaction in the area of....
WILLINGNESS OF STAFF TO "GO THE EXTRA MILE" ON YOUR BEHALF
01 Satisfied 1
02 Neither satisfied nor dissatisfied 2
03 Dissatisfied 3
04 DK/NR 9

25: **OVERL**
Using the same scale, how satisfied were you OVERALL with the information and service you received from Health Canada's seniors and aging programs?
01 Satisfied 1
02 Neither satisfied nor dissatisfied 2
03 Dissatisfied 3
04 DK/NR 9

26: **REAS**
=> +1 if OVERL=#2
What was the main reason you were satisfied/dissatisfied?
01 Response 01
02 DK/NR 99

27: **ALTEN**
Do you think you could have received the same type of information or advice from some other group or agency?
01 Yes 1
02 No . . . . 2 => +3
03 DK/NR . . . . 9 => +3

28: **CURR**
Have you received information or advice from such groups or agencies?
01 Yes 1
02 No 2
03 DK/NR 9

29: **BETTR**
Do you think you could have received better service elsewhere?
01 Yes 1
02 No 2
03 DK/NR 9

30: IMPA2

=> +2 if CALC>64

MESSAGE: CHOOSE ALL THAT APPLY

What was the IMPACT of the information, advice or referral you received through the aging and seniors programs at Health Canada? Did you....

01	Distribute the information or research you received to other colleagues/institutions	01
02	Make additional contacts or networks in your field	02
03	Incorporate the information or research you received into your own work	03
04	Follow-up on a referral you received	04
05	Submit an application for funding	05
06	Improve your knowledge in a particular area	06
07	Change the way you deliver your service/program	07
08	Establish a formal partnership or relationship with another organization	08
09	Improved your perception of seniors and aging in Canada	09
10	Resolution of a concern or problem	10
11	Incorporate a publication in your resource centre/library	11
12	None of the above	12
13	DK/NR	99

31: IMPA3

Were there any other IMPACTS of the information, advice or referral you received from the aging and seniors program at Health Canada?

01	Response	01
02	No other impacts	98
03	DK/NR	99

32: HEATH

=> ISSUC if CALC<65

Did the information, advice or referral help you maintain or improve your health, well-being or independence in any way?

01	Yes	1	
02	No	2	=> +2
03	DK/NR	9	=> +2

33: TYPE

In what way?

01	Response	01
02	DK/NR	99

34: ISSUC

MESSAGE: Please number responses 1,2 and 3

What do you think are the two biggest issues threatening the health, well-being and independence of CANADIAN SENIORS TODAY and in the near future? Please start by giving met the one you consider most important.

01	Response	01
02	DK/NR	99

35: RESP

In the area of aging and seniors issues overall, who do you think should have primary responsibility. Should it be...

01	Government	1
02	Non-profit or voluntary organizations	2
03	Individuals in general	3
04	Seniors	4
05	Other	5
06	DK/NR	9

36: LEVEL

=> +1 if NOT(RESP=#1)

What level of government do you think should have primary responsibility for seniors and aging issues?

01	Federal	1
02	Provincial	2
03	Local/municipal	3
04	DK/NR	9

37: INVOL

Overall, in the area of aging and seniors issues, what would you like to see the federal government do in the future for ALL Canadian seniors:

01	Increase its level of support	1
02	Maintain its level of support	2
03	Reduce its level of support	3
04	Eliminate support	4
05	DK/NR	9

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38: **INVO2**

Overall, in the area of aging and seniors issues, what would you like to see the federal government do in the future for LOW INCOME Canadian seniors:

01	Increase its level of support	1
02	Maintain its level of support	2
03	Reduce its level of support	3
04	Eliminate support	4
05	DK/NR	9

39: **LOWIN**

Some people argue that those who can pay, should, and only low income seniors should receive government-supported services. Do you agree with this statement, disagree or neither agree nor disagree?

01	Agree	1
02	Neither agree nor disagree	2
03	Disagree	3
04	DK/NR	9

40: **PRIOR**

The government will face a number of challenges as Canadians age. For each of the following areas, I'd like you to tell me whether you think the government should, for all Canadian seniors, increase its support, maintain support at the same level it is now, or reduce its support.

41: **PENS**

MESSAGE: ...what the government should do

....income security such as pensions and income tax credits NOTE: IF respondent says increase or reduce, probe from "alot" or "a little"

01	Increase support alot	1
02	Increase support a little	2
03	Maintain support at the same level as now	3
04	Reduce support a little	4
05	Reduce support a lot	5
06	DK/NR	9

42: PBLH

MESSAGE: ...what the government should do

....basic health care coverage NOTE: IF respondent says increase or reduce, probe for "a lot" or "a little"

01	Increase support alot	1
02	Increase support a little	2
03	Maintain support at the same level as now	3
04	Reduce support a little	4
05	Reduce support a lot	5
06	DK/NR	9

43: EBENE

MESSAGE: ...what the government should do

....extended health care benefits for prescription drugs NOTE: IF respondent says increase or reduce, probe for "alot" or "a little"

01	Increase support alot	1
02	Increase support a little	2
03	Maintain support at the same level as now	3
04	Reduce support a little	4
05	Reduce support a lot	5
06	DK/NR	9

44: INTER

MESSAGE: ...what the government should do

....health care benefits for out-of-country care NOTE: IF respondent says increase or reduce, probe for "a lot" or "a little"

01	Increase support alot	1
02	Increase support a little	2
03	Maintain support at the same level as now	3
04	Reduce support a little	4
05	Reduce support a lot	5
06	DK/NR	9

45: AFFOR

MESSAGE: ...what the government should do

....specialized housing (e.g., retirement building with on-site support, adapted housing for seniors, etc.) NOTE: IF respondent says increase or reduce, probe for "alot" or "a little"

01	Increase support alot	1
02	Increase support a little	2
03	Maintain support at the same level as now	3
04	Reduce support a little	4
05	Reduce support a lot	5
06	DK/NR	9

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46: ACCES

MESSAGE: ...what the government should do

....accessible transportation NOTE: IF respondents says increase or reduce, probe for "a lot" or "a little"

01	Increase support alot	1
02	Increase support a little	2
03	Maintain support at the same level as now	3
04	Reduce support a little	4
05	Reduce support a lot	5
06	DK/NR	9

47: HOME

MESSAGE: ...what the government should do

...home care or home support services (e.g., homemaker services, assistance with bathing, meal preparation, nursing, etc.) NOTE: IF respondent says increase or reduce, probe for "a lot" or "a little"

01	Increase support alot	1
02	Increase support a little	2
03	Maintain support at the same level as now	3
04	Reduce support a little	4
05	Reduce support a lot	5
06	DK/NR	9

48: RESPT

MESSAGE: ...what the government should do

....services to help those who are caring for an elderly relative or friend NOTE: IF respondent says increase or reduce, probe for "a lot" or "a little"

01	Increase support alot	1
02	Increase support a little	2
03	Maintain support at the same level as now	3
04	Reduce support a little	4
05	Reduce support a lot	5
06	DK/NR	9

49: PALL

MESSAGE: ...what the government should do

...specialized care services for dying patients NOTE: If respondent says increase or reduce, probe for "a lot" or "a little"

01	Increase support alot	1
02	Increase support a little	2
03	Maintain support at the same level as now	3
04	Reduce support a little	4
05	Reduce support a lot	5
06	DK/NR	9

50: PWELL

MESSAGE: ...what the government should do

....programs and information services on topics like exercise, nutrition, accident-prevention, medication use, etc NOTE: IF respondent says increase or reduce, probe for "a lot" or "a little"

01	Increase support alot	1
02	Increase support a little	2
03	Maintain support at the same level as now	3
04	Reduce support a little	4
05	Reduce support a lot	5
06	DK/NR	9

51: COMMC

MESSAGE: ...what the government should do

....organizations for seniors NOTE: IF respondents says increase or reduce, probe for "a lot" or "a little"

01	Increase support alot	1
02	Increase support a little	2
03	Maintain support at the same level as now	3
04	Reduce support a little	4
05	Reduce support a lot	5
06	DK/NR	9

52: KNOW

MESSAGE: ...what the government should do

...providing information to seniors about health, well-being and independence

01	Increase support alot	1
02	Increase support a little	2
03	Maintain support at the same level as now	3
04	Reduce support a little	4
05	Reduce support a lot	5
06	DK/NR	9

53: INFO

MESSAGE: ...what the government should do

....improving the public image of aging and seniors NOTE: IF respondent says increase or reduce, probe for "a lot" or "a little"

01	Increase support alot	1
02	Increase support a little	2
03	Maintain support at the same level as now	3
04	Reduce support a little	4
05	Reduce support a lot	5
06	DK/NR	9

54: LEAD

MESSAGE: ...what the government should do
...guiding and coordinating other organizations across the country regarding seniors issues

01 Increase support alot 1
02 Increase support a little 2
03 Maintain support at the same level as now 3
04 Reduce support a little 4
05 Reduce support a lot 5
06 DK/NR 9

55: RESE

MESSAGE: ...what the government should do
....research funding on the health concerns of seniors such as osteoporosis or Alzheimers disease NOTE: If respondent says increase or reduce, probe for "a lot" or "a little"

01 Increase support alot 1
02 Increase support a little 2
03 Maintain support at the same level as now 3
04 Reduce support a little 4
05 Reduce support a lot 5
06 DK/NR 9

56: RISK

MESSAGE: ...what the government should do
....benefits for medical devices and aids such as hearing aids and walkers NOTE: IF respondent says increase or reduce, probe for "alot" or "a little"

01 Increase support alot 1
02 Increase support a little 2
03 Maintain support at the same level as now 3
04 Reduce support a little 4
05 Reduce support a lot 5
06 DK/NR 9

57: NONSE

Overall, how would you say non-seniors perceive seniors and aging in Canada today? Would you say people generally have a....

01 positive view 1
02 mixed view 2
03 negative view 3
04 DK/NR 9

58: PRE57

Finally, I would like to ask you a few questions for statistical purposes. I remind you that all of your responses will be protected and no answers will be reported individually.

59: RETIR

=> Q23A if CALC<65

Are you currently retired, semi-retired, a homemaker, employed outside the home or self-employed?

01	Retired	1
02	Homemaker	2
03	Employed	3
04	Self-employed	4
05	Semi-retired	5
06	DK/NR	9

60: I2

=> +1 if NOT(RETIR=#3-#4)

MESSAGE: SELECT ALL THAT APPLY - DO NOT READ CATEGORIES

Are you working full-time or part-time?

01	Full-time	1
02	Part-time	2
03	DK/NR	3

61: VOL

Do you do any volunteer work for groups or organizations? IF YES: PROBE FOR "lots" or "some"

01	Yes, lots	1
02	Yes, some	2
03	No	3
04	DK/NR	9

62: VOLLF

Do you spend time helping out family, friends or neighbours? IF YES: Probe for "lots" or "some"

01	Yes, lots	1
02	Yes, some	2
03	No	3
04	DK/NR	9

63: Q59

What is your current marital status?

01	Now married/common law	1
02	Widowed	2
03	Single (i.e., never married)	3
04	Separated or divorced	4
05	DK/NR	9

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64: **HEALT**

In general, compared to other people your age, would you say your health and well-being is very good, average, or poor.

01	Very good	1	
02	Average	2	
03	Poor	3	
04	DK/NR	9	

65: **DIS**

Do you have a chronic or long-term illness, injury or disability that limits your physical independence?

01	Yes	1	
02	No	2	=> +2
03	DK/NR	9	

66: **SPECI**

MESSAGE: READ CATEGORIES

To what extent would you say your physical independence is limited by an illness, injury or disability? Would you say...

01	A great deal	1	
02	Somewhat	2	
03	A little	3	
04	DK/NR	9	

67: **IMPRO**

Did you do something to improve your health in the past 12 months?

01	Yes	1	
02	No	2	=> +3
03	DK/NR	9	

68: **SINGL**

What is the single most important change you have made in the past 12 months to improve your health?

01	Increased physical activity	01
02	Lost weight	02
03	Changed eating habits	03
04	Managed blood pressure	04
05	Change physical environment	05
06	Acquired an assistance device or medical aid	06
07	Received better care services	07
08	Changed medication use	08
09	Other (specify)	09
10	DK/NR	99

69: HELP

MESSAGE: READ CATEGORIES, CHOOSE ALL THAT APPLY

Did any of the following help you to make this change? Probe: Did any other factors help you to make this change?

01	Support from family or friends	01
02	Increased knowledge of health risks	02
03	Changes in legislation or policies	03
04	Change in life situation	04
05	Advice from health professional	05
06	None of the above	09
07	Other	07
08	DK/NR	99

70: EDUC

What is the highest level of formal education that you have completed?

01	No schooling	01
02	Primary school	02
03	Some high school	03
04	High school graduate	04
05	Some community college/CEGEP	05
06	Community college/CEGEP graduate	06
07	Some university	07
08	Undergraduate degree (e.g., B.A., B.Sc.)	08
09	Graduate or post graduate degree (e.g., M.A., M.Sc., Ph.D.)	09
10	Other (specify)	10
11	DK/NR	99

71: WHERE

MESSAGE: PROMPT WITH CATEGORIES

In what kind of place to you live?

01	Private residence	01	
02	Retirement home	02	=> SIZE
03	Institutional facility	03	=> SIZE
04	Other (specify)	04	=> SIZE
05	DK/NR	99	=> SIZE

72: NUMB

How many people, including yourself, live in your residence?

01	DK/NR	99

73: SIZE

What is the approximate size of the community in which you live?

01	Less than 10,000	1
02	10,000 to 99,999	2
03	100,000 to 1 million	3
04	1 million plus	4
05	DK/NR	9

74: CULT

What is the language you first learned in childhood and still understand?

01 English 01
02 French 02
03 Other 03

Which of the following three statements best describes your current financial situation.

I can meet my needs and still have enough money left over to do the things I want.

I have enough money to meet my needs but have little left over for extras.

I can barely meet my needs and have nothing left over for extras.

@meet
1 - Can meet needs and have money left over
2 - Enough to meet needs but little left over
3 - Must budget carefully
4 - Barely meet needs
9 - DK/NR

75: MEET

01 Extras 1
02 Little for extras 2
03 Barely meet needs 3
04 DK/NR 9

76: HOU

MESSAGE: ALLOW RESPONDENTS CHOICE OF DECLINING TO RESPOND IF NOT COMFORTABLE

Approximately what was your total annual household income before deductions in the year ending December 31, 1995? Would it be....

01 Less that $10,000 1
02 $10,000 to $14,999 2
03 $15,000 to $19,999 3
04 $20,000 to $29,999 4
05 $30,000 or more 5
06 DK/NR 9

77: Q23A

=> SEX if ORG=#1,#3

Does your organization deal primarily with seniors' issues?

01 Yes 1
02 No 2
03 DK/NR 9

78: **Q23B**

What type of organization is this?

01	Direct service provider - health care	1
02	Direct service provider - non-health care	2
03	Research institute, university	3
04	Government	4
05	Community-based seniors organization	5
06	Other (specify)	6
07	DK/NR	9

79: **Q23**

How large is your organization?

01	Less than 10 people	1
02	10 to 99 people	2
03	100 or more people	3
04	DK/NR	9

80: **POS**

What is your position in your organization?

01	Manager, director	01
02	Member of board of directors	02
03	Volunteer	03
04	Employed staff/member of your organization	04
05	Nurse, social worker	05
06	Other (specify)	06
07	DK/NR	99

81: **Q24**

MESSAGE: ENTER NUMBER and THEN ENTER either the MONTHS OR YEARS code.

Approximately how long have you been with this organization?

01	Months	01
02	Years	02
03	DK/NR	99

82: **SEX**

MESSAGE: DO NOT READ

SEX

01	Male	1
02	Female	2

83: **THNK**

MESSAGE: End of Interview

Thank you for your cooperation and time!

01	Completion	1

84: **INT**
MESSAGE: END OF INTERVIEW elapsed:$T $D $H
ENTER COMPLETION CODE

```
                                                      Elimination => 1 (NOT THNK)
01  Completed interview  . . . . . . . . . . . . . . . . . . .  CO        => END
02  A business . . . . . . . . . . . . . . . . . . . . . . . .  BU        => END
03  Number Not in Service  . . . . . . . . . . . . . . . . . .  NF        => END
04  Incomplete interview-->call back . . . . . . . . . . . . .  IC        => CB
05  No answer/Busy/Eligible Respondent not in-> call back   .  NA        => CB
06  Appointment for later time . . . . . . . . . . . . . . . .  AP        => CB
07  Refusal  . . . . . . . . . . . . . . . . . . . . . . . . .  RF        => END
08  Language Difficulty with Respondent/Hearing impairment  .  LN        => END
09  Ineligible to Participate/Screened Out . . . . . . . . . .  IN        => END
10  Unavailable for the Survey Duration  . . . . . . . . . . .  UN        => END
11  Called TEN times without success . . . . . . . . . . . . .  RE        => END
12  Deceased/ TOO ILL TO PARTICIPATE . . . . . . . . . . . . .  DE        => END
13  To be called back by a francophone interviewer.  . . . . .  FR        => CB
14  Incomplete refusal . . . . . . . . . . . . . . . . . . . .  IR        => END
```

85: **CB**
MESSAGE: It is now $h Il est maintenant $H
ENTER A DATE AND TIME TO CALL THIS NUMBER BACK

86: **DUM_1**
=> END if ***0==0***

87: **DUM_2**

88: **DUM_3**

89: **DUM_4**

90: **DUM_5**

91: **DUM_6**

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92: F6
Note fields for interviewers

```
@f6
Name of respondent:     <conta
Telephone number:       <tele

@not1
@not2
@not3
@not4
@not5
@not6
@not7
@not8
@not9
@not10
```

93: NOT1

94: NOT2

95: NOT3

96: NOT4

97: NOT5

98: NOT6

99: NOT7

100: NOT8

101: NOT9

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102: NOT10

```
@F7
NAME OF RESPONDENT: @conta
TITLE:              @TITLE

ORGANIZATION:       @ORGAN

ADDRESS:            @STREE

                    @CITY
                    @PROV
                    @POST
TELEPHONE NUMBER:   @TELE

FILE NAME:          @FILEN
DATE:               @DATE

SOURCE OF LIST:     @LIST (1-made an enquiry, 2-mailing list)
```

103: F7
=> +1 if 0==0

104: CONTA
CONTACT NAME OF RESPONDENT

105: TITLE

106: ORGAN
Organization name

107: STREE
STREET ADDRESS

108: CITY
CITY

109: PROV
PROVINCE

110: POST
POSTAL CODE

111: TELE
TELEPHONE NUMBER

112: FILEN
File number

113: DATE

114: LIST
Imported flag on source of list

```
01  Enquiry  . . . . . . . . . . . . . . . . . . . . . . . . . .   1
02  Mailing list . . . . . . . . . . . . . . . . . . . . . . . .   2
```

115: MAIL1
Mailing list ID

116: MAIL2
Other ID from mailing list

117: F10
Choose among the following themes:

```
01  Client  . . . . . . . . . . . . . . . . . . . . . . . . . .   1        =>
F10_1 . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
02  Confidentiality  . . . . . . . . . . . . . . . . . . . . . .   2        =>
F10_2 . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
03  How did you get my name  . . . . . . . . . . . . . . . . . .   3        =>
F10_3 . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
04  Study topic  . . . . . . . . . . . . . . . . . . . . . . . .   4        =>
F10_4 . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
05  Prompt on why personal information asked in survey.  . . .   5        =>
F10_5 . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
06  Who to call for more information  . . . . . . . . . . . . .   6        =>
F10_6 . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
07  How to access info under Privacy Act  . . . . . . . . . . .   7        =>
F10_7 . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
08  What is the Division of Aging and Seniors  . . . . . . . .   8        =>
F10_8 . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
09  Return to the interview  . . . . . . . . . . . . . . . . .   9        =>
F10_9 . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
```

118: F10_1
This evaluation study is being conducted by Ekos on behalf of the federal department, Health Canada.

```
01  OK, return to the help menu  . . . . . . . . . . . . . . .   1        => F10
```

119: F10_2
All information you give will be protected under the provisions of the Privacy Act. The information collected will be used for research purposes only. The report that will be written will give aggregate totals only, and no comments will be attributed to any individual. If you wish to discuss this survey you may talk to my supervisor, or to the survey coordinator at Ekos, Janice Remai collect at (613) 235-7225.

01 OK, return to the help menu . . . . 1 => F10

120: F10_3
Your name was obtained from a list of clients of the Division of Aging and Seniors at Health Canada. Your name was selected at random for this study and this information was used to contact you. This information was released for research purposes only.

01 OK, return to the help menu . . . . 1 => F10

121: F10_4
This survey is part of research conducted by Health Canada. Interviews are being conducted with almost 300 people who have contacted or received services through the Division of Aging and Seniors. The results of the study will be used by the department to help evaluate the effectiveness of the government's programs for seniors and to improve the programs in the future.

01 OK, return to the help menu . . . . 1 => F10

122: F10_5
Some of the questions in this survey involve personal questions about you.The purpose of these questions is to fully understand how Canadians are affected by aging in all areas of their life. This information is protected by the Privacy Act and information reported will be given in aggregate totals only, no comments will be attributed to one individual.

INDIVIDUAL.

01 OK, return to help menu . . . . 1 => F10

123: F10_6

If you need more information, you may call the survey manager at Ekos, Janice Remai collect at (613) 235-7225. If you want more information about the federal government's seniors program, you may contact the Division of Aging and Senior at Health Canada at (613) 952-7606. If you would like more information about this evaluation study, you may call Linda Ladouceur collect at (613) 957-3897.

01 OK, return to help menu . . . . 1 => F10

124: F10_7

The information you provide will be stored in Personal Information Bank no. HC-002-085-9619. Should you wish to obtain information pertaining to this survey, you may submit a request under the Privacy Act or the Access to Information Act, to Health Canada, stating the specific information you would like, and the personal information bank in which it is stored. Instructions for obtaining this information are provided in the publication "Info Source".

01 OK, return to help menu . . . . 1 => F10

125: F10_8

The Division of Aging and Seniors provides funding for programs and research to address issues around aging and seniors. There were three funding programs until 1995: New Horizons, Ventures in Independence and Seniors Independence Program. These programs were combined in 1995 to form New Horizons:Partners in Aging. The objective of the Division is the improve the health, independence and well-being of seniors in Canada.

01 OK, return to help menu . . . . 1 => F10

126: F10_9

TYPE "ENTER" TO CONTINUE THE INTERVIEW

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APPENDIX G
Letter to Project Sponsors

Strategic Planning and Review Directorate
Policy and Consultation Branch
Postal Locator 0907D
Room 772D, Brooke Claxton Bldg.
Ottawa, Ontario
K1A 0K9

(PHONE NUMBER,
incl. area code,
UNDER "OUR REFERENCE")

June 17, 1996
(NAME & ADDRESS)
Dear Mrs........ or Mr..........:

RE: **TITLE OF PROJECT:** ______
NUMBER OF PROJECT: ______
TYPE OF PROGRAM: ______
PROJECT DURATION: ______

The Program Evaluation Group of Health Canada is currently conducting a study of the various seniors programs funded by Health Canada over the last five years, including New Horizons, Seniors Independence Program, Ventures in Independence and more recently New Horizons: Partners in Aging. Part of the work will involve looking at the kinds of effects these programs have had on the health, well-being and independence of seniors. Information on seniors' current needs is also of interest for this study. We propose to gather this information through a telephone survey. I am therefore writing to you today to seek your assistance in identifying those seniors (65 years of age or older) from your project to whom we should be speaking. The people we are interested in surveying are those:

- ☐ who received a service sponsored by your project (e.g., received meals from a meals-on-wheels service, attended a foot care clinic); or
- ☐ who participated in an activity sponsored by your project (e.g., a choir, a social club, a fitness class, training on nutrition and other health issues for themselves).

For the purposes of this study, however, we are **not** interested in surveying non-seniors or seniors who may not be the direct recipients of your project's services or activities (e.g., not those who have helped in the design or delivery of your project, or seniors who received training to provide services to other seniors, or who participated in a conference designed for delivery agents, etc.). In other words, we would like to survey those seniors who were ultimately intended to be affected by your project.

The survey work would be conducted by the consultant firm we have hired for this evaluation, Ekos Research Associates located in Ottawa. Participation of seniors in the survey would be entirely voluntary and this would be explained to them by the consultant. At the same time, the consultant would also explain to them that their responses would be treated in the strictest of confidentiality; only aggregate data would be included in the final report.

In order to conduct this survey, we would need from you a list which would contain the names, phone numbers (and addresses when the phone number is not available) of 20 seniors who meet the definition provided above. We would appreciate it if you could use the attached form when providing us with this information. If your project has more than 20 names of seniors that meet the definition we would ask that you select 20 names by chance using the following procedure (this is very important for the success of this exercise):

- ☐ Step 1: Indicate the total number of seniors who meet the definition on the attached form in the appropriate space.
- ☐ Step 2: Take this total number of seniors and divide it by 20. The number you get (which we will refer to as "n" in Step 3 below) will give you the skip pattern to use to select the names by chance.
- ☐ Step 3: Start at the beginning of your list of names of seniors and select every "n" the name (using the "n" number obtained in Step 2 above).

If you are unable to provide us with names of seniors please check the appropriate box on the attached form.

The survey will start in the first week of July. I would therefore appreciate it if you could provide us with this information no later than June 28, 1996. The return address appears on the attached form. However, should you have access to a fax machine, we would appreciate it if you could use this means of communication as this would ensure that your information reaches us even faster. Our fax number is (613) 952-9660. It also appears on the form.

Your cooperation in this exercise is extremely important to the success of our study. It is only in talking to these seniors whose lives are touched by the funding provided by Health Canada that we will be able to get a true understanding of how our programs are working.

Should you require additional information regarding this survey or the evaluation study itself, please do not hesitate to call me at (613) 957-3897 or Paul Youldon at (613) 957-3894.

Yours truly,

Linda C. Ladouceur
A/Program Evaluation Project Manager
Evaluation Group
Strategic Planning and Evaluation Division

Encl.

Nous avons établi la préférence linguistique pour cet envoi selon l'information contenue dans nos dossiers. Cependant, si une erreur s'est glissée dans notre système et que vous auriez préféré obtenir la ***version française*** *de cette lettre, prière de communiquer avec Linda Ladouceur au (613) 957-3897 ou Paul Youldon au (613) 957-3894.*

LIST OF SENIORS FOR TELEPHONE SURVEY
*** PLEASE PRINT***

Project title (as per information on letter): ____________________

Project number:(as per information on letter):____________________

Name and phone number of person who filled out this form:_______________

If you cannot provide a list, please list reason(s) (Please make sure to return this form to us even if you cannot provide a list.):____

Total number of seniors on the list you are using for selecting 20 names by chance:____

NAME (in alphabetical order preferably)	TELEPHONE NUMBER (including area code)	ADDRESS (only if phone number missing)
1.		
2.		
3.		
4.		
5.		
6.		
7.		

NAME (in alphabetical order preferably)	TELEPHONE NUMBER (including area code)	ADDRESS (only if phone number missing)
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

Please fax your completed list to Linda C. Ladouceur at (613) 952-9660 or mail it to the following address:

Ms. Linda C. Ladouceur
A/Program Evaluation Project Manager
Evaluation Group
Strategic Planning and Review Directorate
Policy and Consultation Branch
Health Canada
Postal Locator 0907D
Room 772D, Brooke Claxton Bldg.
Ottawa, Ontario
K1A 0K9

APPENDIX H
Rethinking Government Questions

QUESTIONS ON RETHINKING GOVERNMENT '96

1. Following is a list of needs which may be of importance to seniors in Canada today. Which would you say is the most important need among seniors?

    a. financial security
    b. public health care
    c. specialized housing
    d. specialized transportation
    e. personal safety and security
    f. other (only if volunteered by respondent)

2. Beyond basic health care covered by medicare, and thinking specifically about the health, well-being and independence of seniors in Canada today, which one of the following should be a priority for governments in terms of allocating health care resources?

    a. home care or home support services
    b. prescription drugs
    c. medical devices and aids
    d. nursing homes
    e. nothing beyond basic health care
    f. other (only if volunteered by respondent)

3. Overall, in the area of aging and seniors issues, what would you like to see the federal government do in the future for Canadian seniors?

    a. increase its level of support
    b. maintain its level of support
    c. reduce its level of support
    d. eliminate its level of support

APPENDIX I
Rethinking Government Findings

RETHINKING GOVERNMENT

As part of the data collection for this evaluation, three questions were sponsored on *Rethinking Government*, a larger survey exercise carried out by Ekos Research Associates. The survey was conducted during the month of November and involved interviews with 2,962 members of the general public (including 276 seniors).

Results from Rethinking Government

Needs

Respondents were asked to indicate which of five possible needs which may be of importance to seniors in Canada today they felt was the most important. These needs were:

- financial security;
- public health care;
- specialized housing;
- specialized transportation; and
- personal safety and security.

The results are presented in Exhibit 1. Overall, people placed the greatest importance on public health care (44 per cent) followed by financial security (35 per cent). Twelve per cent felt that personal safety and security was the most important need, while six per cent selected specialized housing and one per cent selected specialized transportation.

There were some differences on this variable as a function of subgroups of respondents:

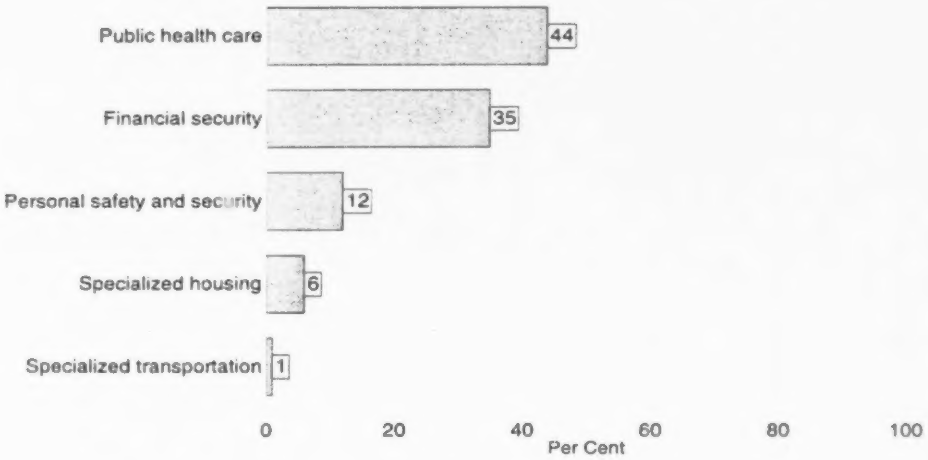
- a higher proportion of respondents from the Atlantic region, Ontario, and Manitoba/Saskatchewan indicated public health care as the most important need (48, 51 and 46 per cent respectively) than from Quebec, Alberta and British Columbia (37, 43 and 37 per cent);

- a higher proportion of respondents whose mother tongue is English than French indicated public health care as the most important need (47 versus 36 per cent); and

- a higher proportion of respondents in the highest household income category (more than $60,000) than in other categories endorsed public health care (48 per cent versus 42, 42, and 43 per cent) while a higher proportion of those in the lowest household income category (less than

EXHIBIT 1

"Following is a list of needs which may be of importance to seniors in Canada today. Which would you say is the most important need among seniors?"



(n=2,962)

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$20,000) than in other categories endorsed specialized transportation (4 per cent versus 1, 1 and 0 per cent).

Interestingly, there were no differences as a function of age, gender, or education.

Priorities

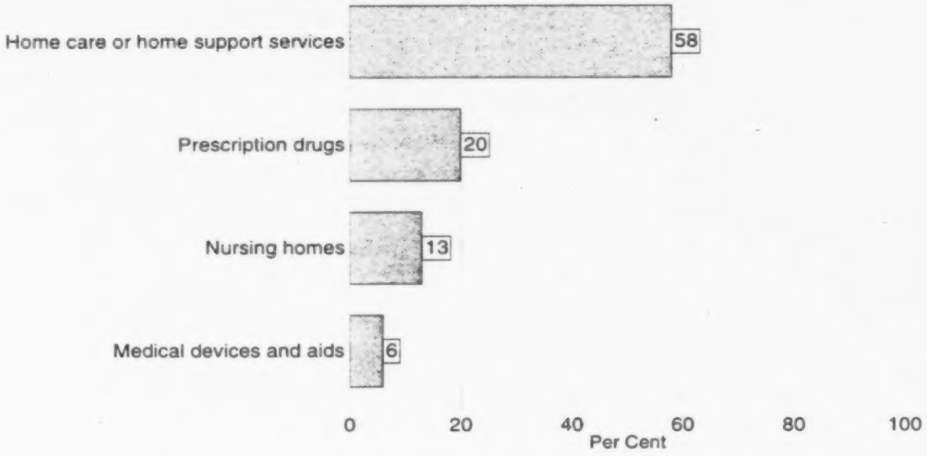
Respondents were then asked to indicate which area, beyond basic health care covered by medicare, they felt should be a priority for governments in terms of allocating health care resources. The areas from which they were asked to choose were as follow:

- home care or home support services;
- prescription drugs;
- medical devices and aids; and
- nursing homes.

The findings are presented in Exhibit 2. The highest priority was accorded to home care or home support services (58 per cent). This was followed by prescription drugs and nursing homes (20 and 13 per cent, respectively), with medical devices and aids receiving the least support (6 per cent).

EXHIBIT 2

"Beyond basic health care covered by medicare, and thinking specifically about the health, well-being and independence of seniors in Canada today, which one of the following should be a priority for governments in terms of allocating health care resources?"



(n=2,962)

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There were few differences among subgroups of respondents:

- a higher proportion of respondents whose mother tongue is French than English endorsed home care or home support services (65 versus 58 per cent), and a lower proportion endorsed prescription drugs (15 versus 22 per cent);
- more respondents in the middle age categories (i.e., 30-44 and 45-64) indicated that priority should be placed on home care or home support services than those in the youngest (i.e., 16-29) and oldest (i.e., 65 +) age categories (63 and 61 per cent versus 53 and 52 per cent respectively);
- a higher proportion of respondents in the oldest age category (i.e., 65 +) endorsed prescription drugs as a priority area than those in the younger categories (29 versus 20, 18 and 17 per cent);

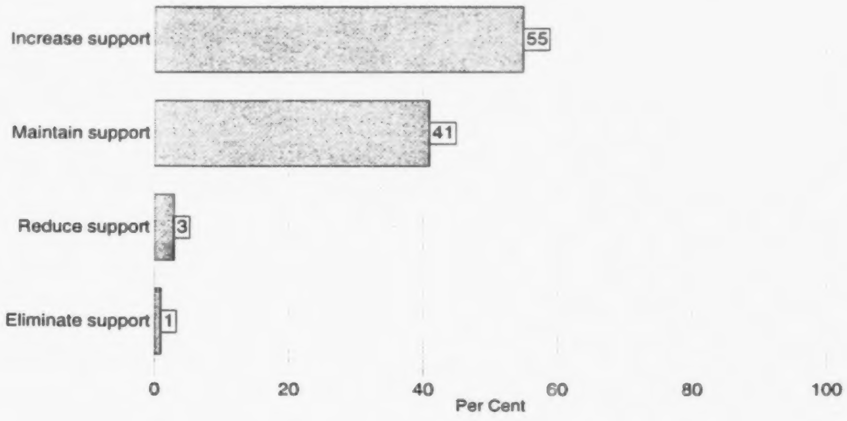
- a higher proportion of female respondents than male respondents selected home care or home support services as the area which should be a priority for governments (63 versus 53 per cent);
- respondents with a college or university education were more likely than those with high school or less to identify home care or home support services as a priority (62 and 62 per cent versus 53 per cent, respectively); and
- respondents in the highest household income category (more than $60,000) were more likely than those in other categories to indicate home care or home support services as a priority (65 per cent versus 54, 56 and 56 per cent).

Level of Government Support

Finally, respondents were asked to indicate whether they felt the federal government should increase, maintain, reduce or eliminate its level of support in the area of aging and seniors issues. The results are presented in Exhibit 3.

EXHIBIT 3

"Overall, in the area of aging and seniors issues, what would you like to see the federal government do in the future for Canadian seniors?"



(n=2,962)

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The majority of respondents indicated that they feel the federal government should increase (55 per cent) or maintain (41 per cent) its level of support. Very few indicated that the federal government should reduce or eliminate its level of support (3 and 1 per cent, respectively).

There were several differences among the various subgroups of respondents:

- ☐ a greater proportion of respondents from the Atlantic region felt the government should increase its level of support than those from the other regions (63 per cent versus 46 to 57 per cent);
- ☐ respondents in the oldest age category (65 +) were more likely to indicate that the federal government should maintain its level of support than increase it (53 and 44 per cent) whereas individuals in the younger categories were more likely to indicate that the government should increase its level of support than maintain it (60 versus 35 per cent for 16 to 19 year olds, 56 versus 40 per cent for 30 to 44 year olds, and 54 versus 41 per cent for 45 to 64 year olds);
- ☐ individuals in the lowest household income category (less than $20,000) were most likely to indicate that the government should increase its level of support (62 per cent) while those in the highest household income category (more than $60,000) were least likely (49 per cent).
- ☐ a smaller proportion of respondents with more education indicated that the government should increase its level of support (51 per cent of those with university education versus 54 per cent of those with college and 59 per cent with high school or less); and
- ☐ a higher proportion of female respondents than male respondents felt the federal government should increase its level of support (61 versus 48 per cent).

There were no differences as a function of language.

Comparison of Results from Rethinking Government with Surveys of Intended Beneficiaries and General Public Clients

Needs

The question which is closest to that asked of *Rethinking Government* respondents asked intended beneficiaries and general public clients what they felt were the top issues threatening the health, well-being and independence of Canadian seniors today.

For intended beneficiaries, health care or chronic illness was the greatest threat (44 per cent), followed by financial issues (26 per cent). Similarly, 57 per cent of general public clients mentioned health care or chronic illness and 42 per cent indicated income security.

These top two issues, therefore, were identified, and in the same ranking, by all three respondent samples.

Priorities

While the questions asked of the three samples concerning priority areas for government differed (i.e., *Rethinking Government* respondents were asked to focus specifically on health), it is still possible to assess relative importance assigned to the health issues addressed in the *Rethinking Government* survey.

From a lengthy list of options, intended beneficiaries indicated that the areas where they felt government funding should be increased were research for funding on seniors' health concerns (64 per cent), services for those caring for elderly people (56 per cent) and home care/home support services (53 per cent). These issues were followed further down the list by benefits for medical devices and aids (42 per cent) and extended health care coverage for prescription drugs (40 per cent).

The top priority according to general public clients was service to help those caring for elderly (77 per cent indicating that government support should be increased). This was followed by support for home care/home support (73 per cent) and research funding on seniors' health concerns (68 per cent). Benefits for medical devices and aid received only moderate support (43 per cent). Extended health care coverage for prescription drugs was much lower on the list of priorities (34 per cent felt support should be increased).

While all three samples strongly endorsed the federal government increasing its support for home care and home support services, the *Rethinking Government* sample differed in the extent to which it place support behind coverage for prescription drugs. While ranked second by *Rethinking Government* respondents, coverage for prescription drugs was considered to be much lower in importance by both intended beneficiaries and general public clients.

Level of Government Support

All three samples were asked, in the area of aging and seniors issues, what they would like to see the federal government do in the future for Canadian seniors. Thirty-three per cent of intended beneficiaries, 38 per cent of general public clients and 55 per cent of the *Rethinking Government* sample indicated they would like to see the federal government increase its level of support.

It is not clear why there is such a large discrepancy between the DAS/S samples and the *Rethinking Government* sample in the proportion indicating that the federal government should increase its support. One explanation may lie in the different contexts of the surveys: while the DAS/S surveys focused explicitly on aging and seniors' issues, the *Rethinking Government* survey focused on a broad range of issues around government and governance. It is possible that the different contexts had an impact on the degree to which respondents endorsed particular response choices. Alternatively, the respondents to the two DAS/S surveys had already participated in a government project or received a government service, hence they may have been responding from the perspective who had direct experience with at least some of the support provided by the federal government. *Rethinking Government* respondents, however, would not have tended to have had this experience and thus may have been responding more naively about the level of support for aging and seniors issues.

The difference in the endorsement of increasing support between the two surveys carried out for the DAS/S evaluation and the *Rethinking Government* survey is made up in the choice to maintain its current level of support: 63 per cent of intended beneficiaries, 56 per cent of general public clients, and 41 per cent of *Rethinking Government* respondents indicated the federal government should maintain its level of support.

APPENDIX J
Members of Expert Panel

EXPERT PANEL

A. *Experts from Canada*

1. Funded Experts

- ❑ Neena Chappell
  Centre on Aging
  University of Victoria

- ❑ Betty Havens
  Department of Community Health Sciences
  University of Manitoba

- ❑ Blossom Wigdor
  Institute for Human Development Life Course and Aging
  Univerity of Toronto

2. Non-funded Experts

- ❑ Satya Brink
  Canadian Centre for Management Development

- ❑ Madge McKillop
  Saskatoon Gerontology Association

B. *Experts from outside of Canada*

- ❑ Rosalie Kane (United States)
  School of Public Health
  University of Minnesota

- ❑ Alan Walker (England)
  Department of Sociological Studies
  University of Sheffield

APPENDIX K
Expert Panel Questionnaire

Questionnaire for Expert Panel

The overall strategic objectives of the Division of Aging and Seniors/ Seniors Strategy (DAS/S) are: to improve and preserve the health, well-being and independence of seniors in Canada; to increase society's understanding and acceptance of aging and seniors; and to eliminate barriers to the involvement and participation of seniors in society. The evaluation of the DAS/S[1] involved: a review of files and literature; interviews with federal and provincial/territorial government officials, funding recipients and stakeholders; and surveys of beneficiaries and the general public (including both DAS/S clients and non-clients). The attached Draft Final Report provides details of the evaluation issues, methodology and draft findings.

The purpose of this questionnaire is to obtain your expert opinion on the relevance and accomplishments of the DAS/S, and on alternatives to the current DAS/S programs *based on your review of the study findings*. We also welcome your suggestions regarding future directions for the DAS/S as well as your critical comments on our Draft Final Report. Please note that this draft document is not for distribution or release. We would therefore ask you *not* to copy this report and to return it to us once you have completed the questionnaire. We will send you a copy of the Final Report when it has been approved.

We are aware that some of the questions we are asking may extend into areas which you feel are beyond your area of expertise. While we are still interested in hearing your perspective, we would also like to know your level of confidence in responding to each. Therefore, **please also provide a rating of the level of confidence you feel in your response** by indicating in the space provided following each question a rating ranging from 1 (*not at all confident, completely outside my area of expertise*) to 7 (*extremely confident, this is my area of expertise*).

I. Program Relevance

1.a. Based on your own point of view, do you feel there is a continuing need for initiatives which enhance the health, well-being and independence of seniors? Why or why not? If yes, for which areas or groups of seniors is the need greatest? (Confidence = _____)

b. Based on the evidence gathered in this evaluation, would you conclude that there is a continuing need for initiatives which enhance the health, well-being and independence of seniors? Why or why not? If yes, for which areas or groups of seniors is the need greatest? If not, what would be more relevant objectives for the DAS/S (if such a program is still necessary)? (Confidence = _____)

---

[1] Registration Number HC-002-085-9619.

c. In your view, are the needs identified in the evaluation report in fact the most pressing needs of seniors? Why or why not? (Confidence = _____)

2.a. Based on your review of the study findings, what do you see as the appropriate *federal* role in addressing issues related to seniors and aging? Given the current fiscal environment, where do you think the priority should be placed for action by the *federal* government? In other words, what conditions faced specifically by seniors could be significantly improved by federal government action? (Confidence = _____)

b. Does the role of Health Canada and the federal government in promoting the health, well-being and independence of seniors continue to be relevant? Why or why not? (Confidence = _____)

3. Is the DAS/S necessary for ensuring that seniors, including those at risk are targeted for programming or are there other programs/initiatives that are addressing these needs? Is there duplication? If yes, where/what programs? (Confidence = _____)

II. Program Accomplishments

4. Given the impacts and effects noted in the findings, do you think the DAS/S has been beneficial for the health, well-being and independence of seniors, including those living in situations of risk? What leads you to hold this view? Would any benefits have been achieved if there were no DAS/S? (Confidence = _____)

5. Has the DAS/S met its short-term objectives, and is it working towards its long-term objectives? (Confidence = _____)

6. Based on your review of the evaluation findings, to what extent has the DAS/S been effective in meeting the high priority needs of seniors and an aging society? (Confidence = _____)

7. Has the DAS/S successfully developed collaborative partnerships? Are any improvements needed in the area of partnerships? (Confidence = _____)

8. To what extent has Seniors Community Programs Funding been effective in: (a) addressing the high priority needs of seniors at risk; (b) enhancing seniors' health, well-being and independence; (c) increasing partnership opportunities; and (d) supporting the development of innovative programming? (Confidence = _____)

9. Do there appear to be gaps in activities or issues left unaddressed by the DAS/S? What are the emerging issues with respect to the health, well-being and

independence of Canada's seniors? Should they be addressed by the DAS/S? If yes, how? If not, by whom? (Confidence = _____)

III. Alternatives

10.a. Based on your review of the study findings, and in light of the top priority needs for seniors/aging as well as diminishing federal resources, do you believe there are more cost-effective approaches/mechanisms for delivering the programs under the DAS/S or meeting the DAS/S objectives? What are they? Are you aware of any other evidence to support these approaches/mechanisms? (Confidence = _____)

b. What structures (e.g., for coordination of the respective roles of different levels of government and delivery agents) would be most appropriate and cost-effective to support these approaches/mechanisms? On what do you base your response? (Confidence = _____)

IV. Study Conclusions

11. In general, and based on the study findings, do you agree with the conclusions of the evaluation? Why or why not? Are there additional conclusions you would draw from the evidence presented in the report? What recommendations would you make?

12. Do you have any other comments you would like to add?

THANK YOU FOR YOUR COOPERATION.

APPENDIX L
Findings from Expert Panel

EXPERT PANEL RESULTS

1a) Based on your own point of view, do you feel there is a continuing need for initiatives which enhance the health, well-being and independence of seniors? Why or why not? If yes, for which areas or groups of seniors is the need greatest?

All respondents

- ☐ All the experts feel that there is continuing need for initiatives which enhance the health, well-being and independence of seniors. The respondents also shared the view that low-income seniors are among those whose needs are greatest.

Funded experts

- ☐ There is a need for such initiatives because of the changing age-structure, family structure and social policy. These changes are affecting seniors and it is essential that initiatives are taken to ensure that the basic needs of seniors are met.
- ☐ There are many areas that have not been fully addressed in terms of social networks, prevention, workplace changes, bioethics, identifying "at risk" seniors in addition to alternatives in shelter arrangements and health systems. These needs, however, vary between regions. Research is also needed on these issues.
- ☐ Aboriginal seniors, caregivers and workers aged between 50 and 65 are also greatly in need.

Non-funded experts

- ☐ Priority should be given to seniors at risk, although all seniors are exposed to some risks. One respondent noted that seniors who are neither completely healthy nor ill enough to be in institutions are primary candidates for policy protection.

International experts

- ☐ Areas where needs are greatest also include housing and homecare services. Ethnic seniors, older senior women and physically and mentally impaired seniors have greatest needs, but these also vary according to regions and locality: there are significant differences between seniors living in rural and city communities, as well as far north and southern communities. One expert expressed doubts on the relevance of community programs and those addressing the image of seniors.

- ☐ The confidence levels for these answers were high, ranging between 6 and 7[1].

1b) Based on the evidence gathered in this evaluation, would you conclude that there is a continuing need for initiatives which enhance the health, well-being and independence of seniors? Why or why not? If yes, [illegible] which areas or groups of seniors is the need greatest? If not, what would be more relevant objectives for the DAS/S (if such a program is still necessary)?

All respondents

- ☐ According to all respondents but two (including one that did not discuss the issue), the evidence gathered in the evaluation indicates that there is a continuing need for initiatives that enhance the health, well-being and independence of seniors.

Funded experts

- ☐ There is evidence in the report that there is a need, and there is a lack of evidence of the contrary. One respondent was impressed by the consistency of support for the goals and priorities from the diverse sources that contributed to the evaluation, with the exception of the respondents from the central agencies. The same respondent mentioned that the mandate of DAS/S should be expanded to include the prematurely retired and older workers.

- ☐ Specific research initiatives should be supported in the areas of Alzheimer's disease, osteoporosis, biochemical changes, nutrition and medication, according to another funded expert. More longitudinal studies should be supported also.

Non-funded experts

- ☐ For one non-funded expert, more than the evidence gathered in this evaluation should be the basis for decisions on specific objectives for the program. There is, however, sufficient evidence for continuing a Federal initiative to enhance the health, well-being, and independence of seniors. These are public goods that must be ensured by government.

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[1] The questionnaire for the experts contained the following: "We are aware that some of the questions we are asking may extend into areas which you feel are beyond your area of expertise. While we are still interested in hearing your perspective, we would also like to know your level of confidence in responding to each. Therefore, please also provide a rating of the level of confidence you feel in your response by indicating in the space provided following each question a rating ranging from 1 (not at all confident, completely outside my area of expertise) to 7 (extremely confident, this is my area of expertise)".

International experts

- ❑ According to one international expert, the evidence supports a need for continuing the initiative, but the qualitative results do not always provide strong evidence. We cannot tell, for example, if the project money is well spent.
- ❑ Needs are greatest for disabled seniors and/or those with low income. There is evidence here that the efforts over the past decade or so were not well targeted, according to this respondent. More emphasis should be put on larger-scale projects and less on the smaller ones. Although the respondent admits that he/she may be missing some Canadian nuances, he/she thinks that the federal government should primarily have a "seeder" role by introducing innovative projects.
- ❑ The confidence levels for these answers ranged between 5 and 7.

1c) In your view, are the needs identified in the evaluation report in fact the most pressing needs of seniors? Why or why not?

All respondents

- ❑ Most respondents agree with the identified needs. They mostly refer to their answers given in the opening question.

Funded experts

- ❑ A strong argument for a health promotion perspective is lacking in the report, according to one expert. Another expert mentioned the absence of older or prematurely retired workers in the report, a group of concern according to the National Forum on Health.

Non-funded experts

- ❑ The first strategic objective of DAS/S (improving health, well-being and independence of seniors) is defensible but the other two are less so. It would be difficult to increase society's understanding and acceptance of seniors and eliminate the barriers to their involvement in an equitable way. It would also be difficult to ensure direct and hard results for these two objectives.
- ❑ Confidence levels ranged between 6 and 7.

International experts

- There are needs for flexible, user-friendly long-term care and personal care programs; livable residentially based programs and appropriate care programs; liveable residentially based programs; and appropriate housing. The other expert added minimising social exclusion, combating age discrimination and supporting caregivers.

2a) Based on your review of the study findings, what do you see as the appropriate *federal* role in addressing issues related to seniors and aging? Given the current fiscal environment, where do you think the priority should be placed for action by the *federal* government? In other words, what conditions faced specifically by seniors could be significantly improved by federal government action?

- Generally speaking, expert panellists are in agreement with other study respondents regarding the appropriate roles for Health Canada. The roles suggested by experts were as follows:
  - developing policy and guidelines (noted by funded, non-funded and international experts); policy should be undertaken in the broadest possible extent so they could be implemented by other public jurisdictions, by organizations and by the private sector — the importance of horizontal policy action and vertical policy delivery was stressed by one non-funded expert who stated that the federal role should be not only to carry out responsibilities within its jurisdiction, but should also ensure individuals have access to public services offered by other levels of government;
  - developing national standards/definitions for programs (noted by funded experts and international experts), ethical research and practice, measures, data elements and training relative to services (noted by funded experts);
  - research (e.g., tracking emerging needs) (noted by funded and international experts) — including the dissemination of findings;
  - coordination and networking (noted by non-funded and international experts);
  - funding (noted by funded and international experts); funding programs only under specific circumstances (e.g., responding to emergent needs) (noted by a funded expert);
  - dissemination of information on successful programs/projects across regions (noted by funded and international experts); and

- consultation based on extant databases and expertise (noted by funded experts).

- The above identified roles were also identified by the experts as priority areas for federal government action.

- Only a few comments were made regarding the conditions facing seniors that could be significantly improved by federal government action. Economic security and health were the two main conditions noted by funded experts. In addition, one funded expert added transportation, eldercare, housing alternatives and the working conditions of older workers. Finally, a non-funded expert emphasized that, while the role is relevant, it is a federal role and not limited to Health Canada; there are many factors related to health, well-being and independence which are not directly health issues (e.g., income, transportation, housing).

- The confidence level was quite high ranging from 5 to 7 on a 7-point scale.

2b) Does the role of Health Canada and the federal government in promoting the health, well-being and independence of seniors continue to be relevant? Why or why not?

- All experts agree that the role of Health Canada and the federal government in promoting the well being and independence of seniors continues to be relevant.

- One funded expert perceives this role to be of continuing relevance because there is much to be done in terms of the needs already identified as well as emerging needs. Additionally, an international expert noted the continuing need for coordination and for ensuring the maximum impact of community-based best practices. Finally, a non-funded expert emphasized that, while the role is still relevant, it is a federal role and not limited to Health Canada; there are many factors related to health, well-being and independence which are not directly health issues (e.g., income, transportation, housing).

- The confidence level was quite high ranging from 5 to 7 on a 7-point scale.

3. Is the DAS/S necessary for ensuring that seniors, including those at risk are targeted for programming or are there other programs/initiatives that are addressing these needs? Is there duplication? If yes, where/what programs?

All respondents

- There are no respondents that mentioned significant duplications, if any.

Non-funded experts

- ❑ It is essential that the present safety net be maintained, especially medicare, Canadian Pension Plan and Old Age Security. According to one expert, the DAS/S is necessary for examining the needs of one population segment — seniors — and to ensure that policies and programs offered elsewhere are responding to their needs. DAS/S should assess the needs, monitor the results and promote actions. DAS/S is less involved, however, in the actual development of policies (assessment of needs, targeting, costs per beneficiary) within the Federal and other governments.

Funded experts

- ❑ According to one funded expert, DAS/S is necessary for ensuring that seniors are targeted for research, policy development and other programming. More coordination and collaboration within the federal government and across jurisdictions and organizations is desirable.
- ❑ Another expert wrote that if there is any duplication, it would be a false argument for getting rid of programs because there is so little done for what is needed.

International experts

- ❑ One respondent did not feel confident in answering and finds that the evidence shown in the report does not clearly answer this question.
- ❑ Confidence levels varied between 2 (international experts) and 7.

II. PROGRAM ACCOMPLISHMENTS

4. Given the impacts and effects noted in the findings, do you think the DAS/S has been beneficial for the health, well-being and independence of seniors, including those living in situations of risk? What leads you to hold this view? Would any benefits have been achieved if there were no DAS/S?

- ❑ Overall, the experts agreed that DAS/S has improved the health, well-being and independence of seniors.
- ❑ Most, but not all, also agreed that this was true for "at risk" seniors, especially since the reorientation of the programs. One international expert, on the other hand, felt that the evidence suggested that DAS/S had not targeted those most "at risk".

- ☐ In comments which may pertain more to conclusions and recommendations, a Canadian non-funded expert suggested that DAS/S could be "far more beneficial" if its efforts were concentrated on being a catalyst (e.g., IDCSI, Framework on Aging) instead of on primary delivery. The reason for this was that DAS/S influences such a small part of the effort required to ensure health, well-being and independence.

- ☐ There was some agreement that DAS/S filled a unique and necessary role in Canada. The finding that mental well-being was one of the more frequently reported results of various programs was very positive in the eyes of one expert. This expert, who was also a DAS/S funding recipient, indicated there was considerable evidence that good mental health is reflected in a more active lifestyle and frequently in better general health.

- ☐ A number of the experts cautioned that the amount of evidence that actually substantiated the conclusion that DAS/S was beneficial was rather limited. They pointed to a lack of "sensitive sophisticated measures" from recipients themselves (i.e., a control and treatment group design).

- ☐ Confidence levels ranged between 6 and 7.

5. Has the DAS/S met its short-term objectives, and is it working towards its long-term objectives?

- ☐ Most experts agreed that DAS/S had made significant progress in meeting all of its short-term goals.

- ☐ The experts also felt that DAS/S was working constructively towards achieving its long-term objectives. Concerning these objectives, one international expert felt that the elimination of barriers to participation did not seem to have the same priority as the other two objectives.

- ☐ A Canadian non-funded expert who agreed that DAS/S had met its short-term objectives and had made efforts to sharpen its long-term objectives, cautioned that DAS/S had had good outputs but not good outcomes for individual seniors.

- ☐ Confidence levels ranged from 4 to 7 (although only one expert rated their confidence as a 7).

6. Based on your review of the evaluation findings, to what extent has the DAS/S been effective in meeting the high priority needs of seniors and an aging society?

- ☐ Experts were divided on the question of whether or not DAS/S had been effective at meeting high priority needs. The general view was that DAS/S had been moderately effective, with one expert (a DAS/S funding recipient) pointing out that this was difficult to assess given that many DAS/S impacts could only be felt indirectly by intended beneficiaries.

- ☐ Some experts (both funded and non-funded) focused on one of the major identified risks, namely economic security. They felt it was important that the issue of economic risk be more clearly addressed by DAS/S, especially given the importance of economic security as a determinant of health and because of the emergent needs of the still insufficiently identified vulnerable sub-population of aging Canadians (i.e., the "prematurely retired" and older workers) as very closely related to this area.

- ☐ Confidence levels ranged between 4 and 7.

7. **Has the DAS/S successfully developed collaborative partnerships? Are any improvements needed in the area of partnerships?**

- ☐ The experts' comments were informed both by the evaluation evidence and by their personal knowledge of the program.

- ☐ Overall, experts were confident that DAS/S has been successful in developing partnerships throughout its existence. For example, according to one expert's "detailed knowledge of all of the SIRP projects" all of them have involved multiple partnerships. This expert was a DAS/S funding recipient.

- ☐ Some experts, mainly the foreign experts who were less sure about the success of DAS/S in the area of partnerships, felt that there was still room for improvement, particularly with respect to voluntary and seniors' organizations, as well as with the private sector.

- ☐ One expert (a Canadian who did not receive DAS/S funding) argued that partnerships in community programming is not necessarily where the DAS/S should concentrate in its federal role since partnership in community programs is not a public good requiring expenditures of tax payers' money. Rather, partnerships with key policy centers for income security, health and social services would be more effective.

- ☐ Confidence levels ranged from 3 (one expert) to 7 (three experts).

8. To what extent has Seniors Community Programs Funding (SCP) been effective in: (a) addressing the high priority needs of seniors at risk; (b) enhancing seniors' health, well-being and independence; (c) increasing partnership opportunities; and (d) supporting the development of innovative programming?

- ❑ Comments regarding Seniors Community Programs Funding were as follow:
  - ❑ while Seniors Community Funding Programs have been somewhat effective in addressing the needs of seniors at risk (funded and international experts), they have not addressed all high priority needs, namely economic security (funded expert) — this was further elaborated on by a non-funded expert who commented that social, recreational, participatory and mental benefits were not high enough priority needs to justify public expenditures: this expert further stated that the direct and hard benefits in priority areas were insufficient for the level of public expenditure — one international expert also commented that there is no way of really knowing if SCP has been effective or not;
  - ❑ there are differing opinions as to whether health, well-being and independence have been addressed — one funded expert and one international expert feel health and well-being have been addressed, but not so much independence and another funded expert feels that the community funding program has been most effective in addressing independence;
  - ❑ while all experts feel there has been progress made by community programs in increasing partnership opportunities, some experts feel the program has been much more successful at accomplishing this (funded experts) than others (international experts — one international expert indicated not being sure);
  - ❑ there are mixed views, with none of them being overly positive, as to whether community funding programs have supported the development of innovative programs. Although a funded and an international expert felt there had been at least some support for innovative programs, another funded expert indicated being uncertain as to the extent to which it has been an outcome.
- ❑ Most expert panellists were not as confident overall in their opinions regarding the effectiveness of Seniors Community Programs Funding (an international and a funded expert rated their confidence a 4 on a 7-point scale). The exception to this was one non-funded expert who rated her confidence level a 7.

9. **Do there appear to be gaps in activities or issues left unaddressed by the DAS/S? What are the emerging issues with respect to the health, well-being and independence of Canada's seniors? Should they be addressed by the DAS/S? If yes, how? If not, by whom?**

- The experts panel provided a wide variety of suggestions on emerging issues with respects to the health, weli-being and independence of Canada's seniors. A listing of these issues includes:

  - aging of people with intellectual disabilities;
  - older caregivers;
  - dementia and impacts on families;
  - public and private interface in terms of long term care;
  - self-help strategies;
  - age discrimination;
  - improvements of quality of life in institutions;
  - investigate and promote forms of care that are affordable, flexible, consumer-centred and consumer-directed;
  - developing productive roles for longer retirement years;
  - greater information available to seniors at pivotal times (e.g., in the hospital);
  - ways to train, supervise, empower and compensate front-line staff who deal with programs fostering independence of seniors with disabilities;
  - research and policy/program response to issues around the income and health impacts of prematurely retired and older workers;
  - impacts of the new information economy and the growth of non-standard work for work and for retirement of future seniors;
  - ethical issues in the health care and well-being of seniors; and
  - the "old-old".

- The two experts who commented felt that these emerging issues could and should be addressed by DAS/S. The recommended role of DAS/S involved advocacy, research and policy and program responses to the issues.

- Experts' confidence in responding to this item was high — the majority rated their confidence a 7 on a 7-point scale.

10a) Based on your review of the study findings, and in light of the top priority needs for seniors/aging as well as diminishing federal resources, do you believe there are more cost-effective approaches/mechanisms for delivering the programs under the DAS/S or meeting the DAS/S objectives? What are they? Are you aware of any other evidence to support these approaches/mechanisms?

10b) What structures (e.g., for coordination of the respective roles of different levels of government and delivery agents) would be most appropriate and cost-effective to support these approaches/mechanisms? On what do you base your response?

- ☐ In general, the experts were cautious in their comments about cost-effectiveness. Most agreed that it is difficult to measure cost-effectiveness of human services and there was little evidence to dispute the current approaches mechanisms used for delivering the program under DAS/S.

- ☐ Overall, there was a sense that DAS/S was reasonably cost-effective. According to one expert, the evolution of the program has led to greater cost-effectiveness. The experts appeared to agree with the guiding principles regarding cost-effectiveness, however, one expert noted that greater adherence to these principles would lead to only marginal improvements to cost-effectiveness.

- ☐ The suggestions for alternative mechanisms/structures for DAS/S included:

  - ☐ greater restrictions on community funding programs (one expert suggested that federal funds be available for evaluation purposes only, another suggested that funds be distributed more selectively), a third suggested DAS/S divest itself of this role;

  - ☐ institutionalized meetings of co-ordinating groups (IDCSI, federal/provincial/territorial);

  - ☐ higher profile for NACA (e.g., annual brief on the status of seniors in Canada presented to the Prime Minister);

  - ☐ higher profile or more central organizational location of DAS/S to be clearly identified as the primary centre of research/policy on aging and seniors both inside and outside of the government;

  - ☐ greater monitoring;

  - ☐ greater stakeholder participation (e.g., representatives of Human Resources Development Canada, Finance Canada located with DAS/S);

  - ☐ greater attention to up-front setting of priorities based on consultations with seniors and other organizations;

- new incentive programs such as a tax credit for seniors who have lived independently of the health system for a year;
- the use of a "lifecycle perspective" was suggested by one expert as a way to improve DAS/S. A lifecycle perspective would improve relations with other orders of government/other federal department, would avoid competitive aspects of inter-generational work, and permit joint funding and multiplier effects;
- setting of clear performance measures against which public programs would be assessed (e.g., decrease poverty, increase home care services); and
- stronger structural linkages with research funding organizations, foundations and the private sector.
- Experts' level of confidence in responding to this item varied widely. Responses ranged from 3 to 7 on a 7-point scale.

11a) In general, and based on the study findings, do you agree with the conclusions of the evaluation? Why or why not?

Canadian-Funded

- Both agree: consensus seems to support the relevance of DAS/S and NACA and the importance of having identifiable units to deal with issues of aging and seniors.

Canadian-non-Funded

- Agree

International

- The study conclusions were extremely cautious. It does seem that the study of the general public showed willingness to support the federal efforts on behalf of older people. Also, it was interesting that health care coverage is of great concern to seniors and that there is some perception of insufficiency in the guarantee to meet costs of health care.
- Agree with the general conclusions: they are supported by evidence and by own knowledge of DAS/S.

11b) Are there additional conclusions you would draw from the evidence presented in the report?

Canadian-Funded

- ☐ Would reinforce the statements in the report in the section on Essential Areas for DAS/S.
- ☐ Would have attributed greater weakness to research funder partnerships (i.e., link to NHRDP), although sense is that, on balance, the same general conclusions would emerge.
- ☐ Feel that the structural changes to secure a higher and more central profile in the federal government is more critical and central to the long-term goals and survival of DAS/S (note: the conclusion is in the document already, but would prefer it to be more strongly worded).

International

- ☐ No definitive statement on the effectiveness and cost-effectiveness of these programs is possible.
- ☐ Would conclude that it is time to have some high-level reconsideration of the goals of senior initiatives.
- ☐ Would have liked to see a conclusion about the value of national longitudinal studies and ways to strengthen these efforts.
- ☐ One expert would have been more wholehearted in their endorsement of DAS/S activities than the report.

11c) What recommendations would you make?

Canadian-Funded

- ☐ A more effective mechanism for multi-sectoral decision-making should be sought.
- ☐ Reassert the emphasis on aging (tomorrow's seniors) as well as seniors.
- ☐ Maintain the existing divisional entity or unit.
- ☐ Maintain the existing long-term objectives, but with greater emphasis in all aspects of the DAS/S on addressing issues of economic security.
- ☐ Modify the short-term goals to incorporate:

- even more targeted funding of community programs; and
- greater emphasis on the structural linkages to more research funders.

❑ Broaden the targeted (at risk) groups to include the "prematurely retired" and older workers.

❑ Structurally relocate DAS/S to report directly to the Minister.

❑ Create mandated structural linkages to the research funding agencies.

❑ Add as a new short-term objective "to coordinate the Canadian participation in the 1999 United Nations designated International Year of Older Persons".

Canadian-Non-Funded

❑ Priority for services should be given to seniors at risk.

❑ The federal government should be responsible for establishing and maintaining national standards.

❑ It is essential that the present social safety net be maintained (i.e., medicare, OAS, CPP, GIS).

❑ Work needs to continue to present a realistic view of today's seniors.

❑ The federal government should develop a more structured relationship with voluntary organizations to ensure their input in policy decisions.

❑ Would recommend a strengthening of such a focal point for seniors in government, providing the means by which individual seniors would draw direct improvements to their independence and increase the probability of independence.

International

❑ The role and visibility of NACA needs to be structurally enhanced.

❑ The funding programs in the community should be continued but more closely monitored and that selection processes and priority-setting need strengthening.

❑ However, would not overload the grant program with too much evaluative requirements and administrative reporting.

❑ Reaffirm long-term strategic goals.

- ☐ Work in closer collaboration with seniors' organizations.
- ☐ Greater priority to empowerment and prevention.
- ☐ Continued targeting on those at greatest risk.
- ☐ Involvement of seniors in research.
- ☐ Greater international collaboration.
- ☐ Careful monitoring of program impacts.
- ☐ Concentrate on essential federal activities of coordination, information sharing, dissemination and funding (seed and long term).

12. Do you have any other comments you would like to add?

Canadian-Funded

- ☐ Arms length advisory councils have a role to play, however, there must be a climate of support or desire for such a source of advice by the minister and deputy minister. If the support is not forthcoming, NACA may have lost its impact. If there is a strong identifiable unit as the central focus for DAS/S, then many or most of NACA's functions (e.g., research, position papers, information) could be taken over by it. Regional representation could be achieved through the regional or provincial advisory councils or secretariats.

Canadian-Non-Funded

- ☐ The evidence justifies a shift away from trying to do the same thing better to getting better results by doing things differently.
- ☐ If the results of the evaluation are to be used by government to make sure DAS/S or its successor is to be effective for the next 20 years, then it should deal with future policy orientations as well as current problems. Questions such as would seniors adopt technology at the same rate as the rest of the population are important for independence if governments and businesses relied on technology to deliver programs and services.
- ☐ DAS/S has a sensitive role within government because it should inform and advise, but not advocate and lobby. It may be a good idea to build on this, strengthening the research and information capability so that it can substantiate issues for policy action and inform organizations and the public on the policies and programs available.

- It would perhaps be wise for DAS/S to shed or to divest to another agency the program role (it can be done better elsewhere). Its role of advisor is then one of a national perspective benefitting citizens without it being muddied by community concerns.

International

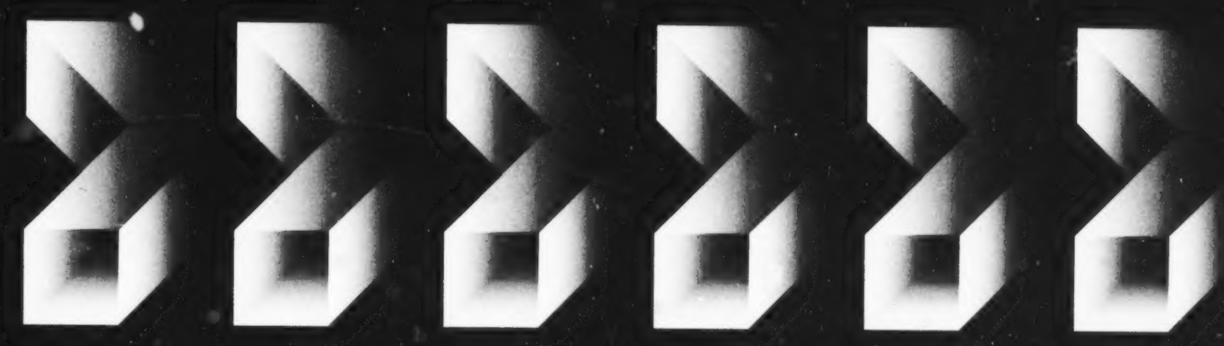
- Insufficient attention has been paid to the leading international role played by DAS/S. The evaluation should acknowledge the high esteem in which the DAS/S is held in other countries and the significance of its publications. The publications, for example, have been well-received. Perhaps this suggests that DAS/S has not itself sufficiently applied international research and good practice to improving the well-being of older people. I would have liked to see DAS/S networking more actively with organizations and individuals in other countries and therefore acting as a two-way channel for research and good practice.

Health Canada Santé Canada

Evaluation Group **Groupe de l'évaluation**

Strategic Planning and Review Directorate **Direction de la planification stratégique et de l'examen**

Policy and Consultation Branch **Direction générale des politiques et de la consultation**



Evaluation of the Division of Aging and Seniors/Senior Strategy Recommendations

March 1997

Canada

MISSION STATEMENT

The Evaluation Group helps Health Canada serve Canadians better by providing objective information and advice about the effectiveness of departmental activities and services.

ÉNONCÉ DE MISSION

Le Groupe de l'évaluation aide Santé Canada à mieux servir les Canadiens et les Canadiennes en offrant une information et des conseils objectifs sur l'efficacité des activités et des services du Ministère.

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EVALUATION OF THE DIVISION OF AGING AND SENIORS/ SENIORS STRATEGY

RECOMMENDATIONS

An evaluation of the Division of Aging and Seniors/Seniors Strategy (DAS/S) was conducted between May and December 1996. Ekos Research Associates Inc. assisted the Evaluation Group, Strategic Planning and Review Directorate, in the conduct of this study. The six recommendations that flow from the findings of the evaluation are listed below. It should be noted that the recommendations are of two types:

1. Recommendations No. 1 and 2, as well as some aspects of Recommendation No. 3 address more specifically concerns expressed by the Office of the Auditor General in its report of November 1995. Consequently, these recommendations are aimed more at the central agencies.

2. The remaining aspects of Recommendation No. 3 as well as Recommendations No. 4, 5 and 6 are aimed more precisely at Health Canada.

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Based on the findings of the DAS/S evaluation, it is recommended that:

RECOMMENDATION NO. 1

- **that the federal government continue to play a role in addressing seniors and aging issues.**

  Despite advancements made in some areas (e.g., the public pension system), seniors in Canada still find themselves in situations of risk or potential risk. According to the literature reviewed for this evaluation, these conditions of risk are exemplified by seniors' poverty rate, their health care needs, and their need for more assistance with daily living as they age. The literature also revealed that, overall, seniors are at least as "at risk" as some other "at risk" groups (e.g.,children). It further identified those seniors most "at risk" to be: seniors with limited incomes (mainly women) , Aboriginal seniors, and seniors living in isolated or rural areas.

  For most respondents of the evaluation, the federal government has a role in addressing seniors' needs. In fact, for many respondents the aging of the population in and of itself justifies the existence of a federal government unit responsible for addressing aging and seniors issues in order to prepare the ground for tomorrow. They see the federal government as being able to play a needed leadership role by providing a broad national perspective, developing national policies and legislation, and establishing national standards, guidelines and strategies. They also see the federal government as having a crucial role to play in coordinating the seniors and aging programs of different levels of governments, as well as in gathering and disseminating information addressing seniors' needs, mainly because there is no other authority that could ensure these activities are carried out across the provincial/territorial governments. Respondents (including provincial/territorial government representatives) found that, while there might be some occasional duplication, in general, DAS/S activities mostly complemented those undertaken by the provincial/territorial governments. Duplication that does exist is seen to be the result of some communication gaps between federal and provincial/territorial authorities at the regional level.

RECOMMENDATION NO. 2

- **that Health Canada continue to have the lead role within the federal government on matters pertaining to seniors and aging.**

While seniors have a number of specific needs, health care and income security were noted as their primary needs by key informants. These two issues were also seen as the two biggest ones threatening the health, well-being and independence of Canadian seniors by the intended beneficiaries of community projects, the general public clients of the Division of Aging and Seniors (DAS) and the participants to the survey *Rethinking Government*. The proportions of participants who identified health care and chronic illness as the main issue varied among the three surveys between 44 per cent and 57 per cent. The proportions who identified income security varied between 26 to 42 percent. These findings support the point of view of most key informants and experts who believe that the importance placed on health care as a major seniors issue justifies leaving the responsibility for seniors with Health Canada, while still ensuring that income security needs of seniors are addressed.

Health Canada's new Population Health Strategy (PHS), which is based on the health determinants model, seeks to improve population health by taking into account all the factors and conditions of risk (including income) that may apply across the entire population, or to particular sub-groups within the population, such as seniors. Improving health is then seen as a shared responsibility that requires the development of healthy public policies in areas outside the traditional health system, as well as collaboration among different sectors and levels of government. In this regard, Health Canada (HC) already assumes a coordination role between different departments and different levels of government. The Interdepartmental Committee on Seniors Issues (IDCSI) (which it chairs) and the federal/provincial/territorial meetings it organizes are two ways in which it pursues this coordination. The Department has also developed the Framework on Aging which was approved last June by the federal/provincial/territorial Ministers Responsible for Seniors.

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RECOMMENDATION NO. 3

- **that Health Canada continue to play its current roles in addressing seniors and aging issues.**

Most interview respondents agreed that the appropriate roles for HC should involve: policy development and leadership, intra and intergovernmental coordination, knowledge development and dissemination, health promotion and disease prevention, and a role as champion of seniors' and aging issues. These roles correspond very closely to those that the Department currently plays in the field of seniors and aging issues.

For many interviewees, however, there was less consensus on the relevance of certain functions that contribute to the roles mentioned above. For example, a number of HC officials, mainly in the regions, suggested that research was not always in sync with the needs of seniors and its impacts on seniors were at best indirect. On the other hand, other respondents from HC, mainly at Headquarters and those involved in research and policy development, as well as those from the IDCSI and the provinces/territories felt that the provinces/territories and community organizations were better positioned to set priorities and implement programs at the community level. These respondents felt that HC should only be involved in demonstration and innovative projects, and the dissemination of their results nationally.

As pointed out earlier, funding of both research and community projects, as well as other functions, can contribute to the various roles recommended for HC. Given the current climate of fiscal restraint, the limited resources available for seniors and aging issues under the PHS will have to be allocated among these various functions in the most strategic way possible, i.e., in a way that will allow HC to meet its new operational objectives for seniors and aging issues under the PHS in the most cost-effective way.

RECOMMENDATION NO. 4

- **that Health Canada enhance its knowledge development and dissemination role.**

As the national lead on seniors and aging issues, HC must possess (and be able to make available to its partners) useful and timely information for evidence-based decision making. This means that the Department should be implementing internal projects or supporting projects (whether community projects or research projects) from which lessons can be learned and which help to fill knowledge gaps. For example, selecting projects that have a strong innovation component is one way of ensuring that they will be contributing new knowledge.

HC should also ensure that all of its projects (both internal projects/activities and funded projects) have built-in evaluation strategies. Lack of information on the outcomes and the cost-effectiveness of the DAS/S's various projects and activities was one of the weaknesses noted at the time of the evaluation[1]. This means that there exist large sums of expenditures for which the Department has very limited information on results achieved. If HC is to play a leadership role in the field of seniors and aging issues, it must start by setting the example in the crucial area of performance measurement, and more specifically outcomes measurement. An evaluation framework was first developed for the DAS/S in 1995. This document should be updated with special care given to revisiting the objectives (as adapted to the new PHS environment), the performance indicators and the required data collection mechanisms. It will then be important for HC to ensure that project evaluations are carried out.

The final steps in the process will involve the consolidation of all the information generated (e.g., synthesizing research findings and lessons learned from project evaluations) and its dissemination. HC should also put in place a mechanism that would allow it to check, on a regular basis, if the information produced and its format are meeting users' needs (e.g., clientele survey).

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[1] It should be noted that the absence of project evaluations for a substantial number of the projects reviewed was due to differing program requirements (some programs did not request that an evaluation be carried out) as well as to the fact that some projects reviewed were ongoing or had just been completed. As a requirement for funding, the new program called " New Horizons: Partners in Aging" requires that all its projects carry out an evaluation of their activities.

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RECOMMENDATION NO. 5

- **that Health Canada continue its targeting of "at risk" seniors while strengthening its preventive measures reaching seniors in general.**

Over the years, budget cuts have necessitated a tighter selection of projects/activities. The DAS/S started giving priority to seniors most in need in 1988 with the implementation of the Seniors Independence Program and to "at risk" seniors in 1993. New Horizons: Partners in Aging (from 1995 on) specifically focusses its efforts on meeting the needs of seniors "at risk" or on preventing situations which put seniors at risk. Other DAS/S activities also target "at risk" seniors (e.g., Seniors Independence Research Program, activities on medication and seniors).

Given the continuing government emphasis on financial restraints, the need for prioritization of expenditures remains of crucial importance. However, many of the persons interviewed in the course of the evaluation believed that targeting only "at risk" seniors may be too short sighted. For many, projects should have a preventive orientation that reaches more seniors in order to prevent future problems. For example, evidence from the literature review shows that prevention measures such as physical activity are linked to the prevention of several chronic illnesses. The DAS/S currently has a number of projects/activities that have a preventive orientation that reaches the seniors population at large (e.g., injury prevention). What would be required would be for HC to strengthen its preventive activities for seniors in general while still retaining as its main focus "at risk" seniors. HC should aim to accomplish this in partnerships with others.

Furthermore, it will be important that decisions regarding preventive action for seniors continue to be evidence-based. For example, in prioritizing its future expenditures, HC will want to keep in mind the following findings from the evaluation:

- Those seniors most "at risk" were identified to be: (a) seniors with limited incomes (mainly women), (b) Aboriginal seniors, and (c) seniors living in isolated or rural areas.
- The three top priorities for increased government support as identified by both intended beneficiaries of community projects and general public clients of the DAS

are: (a) funding for research on seniors' health concerns, (b) caregiver support, and (c) homecare/home support services. (Findings from projects funded under the new Health Transition Fund can further assist decision-making in respect to these last two items.)

RECOMMENDATION NO. 6

- **that Health Canada address other areas of improvement identified in the evaluation.**

In addition to those areas of improvement already identified under previous recommendations, Health Canada should also:

- improve the coordination and communication between Health Canada's Headquarters and regional offices, between Health Canada's regional offices and provinces/territories, and between Health Canada and other federal government departments;
- work on developing more partnerships with external organizations, specifically with the private sector; and
- improve certain aspects of the project selection and approval processes for both research and community projects (e.g., short time frame for completion of application, slow process for obtaining funding, short time frame allowed for project start-up).

TABLE 1
Location of Responses to Evaluation Questions Contained in the Terms of Reference for the Evaluation of the Division of Aging and Seniors/Seniors Strategy

	Evaluation Questions	Page
1.	Is there still a need for a program dedicated to enhancing the health, independence and well-being of seniors? If so, which groups of seniors and which priority needs should such a program address and why (i.e., on what evidence are these priorities based)?	71-116
2.	Is there a continuing role for the federal government and Health Canada to intervene in the promotion of the health, independence and well-being of seniors? What is the mandate under which the Department acts in this area?	94-108
3.	Has the DAS/S met its short term goals, without significant unwanted outcomes? To what extent does the work accomplished to date contribute to the DAS/S' long-term strategic directions?	117-170
4.	To what extent has the DAS/S addressed priority needs of seniors and an aging society?	128-135 154
5.	To what extent has the DAS/S had a direct impact on the health, independence and well-being of seniors, including those seniors living in situations of risk?	136-140 154
6.	To what extent has the DAS/S induced its partners, including seniors, to contribute resources, either financial or in-kind, to collaborative/partnership activities?	124-128 140-145 149-150
7.	To what extent has the DAS/S increased knowledge on, and the number of useful available resources to and for seniors and an aging society?	150-153 161-162
8.	To what extent has seniors community program funding: enhanced seniors' health, independence and well-being; addressed the priority needs of seniors in situations of risk or in danger of being at risk; supported the development of innovative programming; and increased the collaboration/partnership opportunities among seniors, and between seniors and other sectors of society on issues pertaining to seniors and aging issues?	130-146
9.	What have been the effects of the seniors community funded projects, beyond the direct benefits generated, in terms of continuing/new projects, activities and collaboration/partnership after the initial funding ceased? What were the characteristics of those projects that had on-going benefits?	130-146
10.	Which DAS/S activities and projects were most effective? What characterized the most effective projects and activities from the less effective ones?	128-170
11.	Do the various activities of the DAS/S, other departmental activities, and activities outside the Department complement and supplement one another or is there overlap and duplication?	110-116
12.	What mechanisms or approaches would be most cost-effective and appropriate for the federal government and Health Canada to pursue in light of governmental and non-governmental priorities and concerns in the area of seniors and aging and in light of diminished resources?	171-185
13.	What would be the most cost-effective and appropriate structures for supporting these mechanisms or approaches?	176-190

TABLE 2
Location of Responses to Other Evaluation Questions Contained in the Evaluation Framework but not Specifically Addressed by the Research

	Evaluation Questions	Page
1.	To what extent has the DAS/S supported the development of innovative programming?	140-145 149-150
2.	To what extent have the collaboration/partnership projects and activities supported by the DAS/S contributed to meeting the priority needs of seniors?	124-128 140-145 149-150
3.	To what extent has the DAS/S contributed to the development, improvement and/or expansion of services designed to enhance the health, independence and well-being of seniors?	143-145
4.	To what extent has the DAS/S added to the knowledge of the factors that will assist seniors in situations of risk or in danger of being at risk to retain or enhance their health, independence and well-being?	150-153 161-162
5.	To what extent have SIRP projects and activities added to the knowledge of the social, economic and health determinants of the independence of seniors and approaches to the care and treatment of aging related conditions and diseases?	150-153
6.	Has the DAS/S implemented a strategy to manage and disseminate the knowledge generated by DAS/S activities and projects?	151-153 161-162
7.	To what extent has the DAS/S influenced policies and programs of Health Canada, other federal government departments, and the private and voluntary sectors directed to seniors and an aging society? In what way? What methods are most successful?	155-156 159-161
8.	To what extent has the DAS/S promoted and increased the realistic portrayal of aging and seniors?	145-146
9.	Could the same or greater impacts have been achieved through other less costly activities or more efficient use of resources?	185-190
10.	Were appropriate systems established or mechanisms utilized to coordinate, monitor and evaluate the DAS/S?	174-176